Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
APPENDIX B-3.a. "Number of Individuals Served"

The first significant change from the approved Autism Waiver (2003 - 2007) in this renewal application for January 1, 2008 is the number of unduplicated participants projected for each year of the renewal. Year five (2007)of the approved waiver projected 600 participants receiving services. However, Indiana determined that it will not be able to achieve this number by December 31, 2007. Therefore, based on updated projections, this 5-year renewal anticipates serving the following unduplicated participants:
Year 1 (2008) 430
Year 2 (2009) 480
Year 3 (2010) 530
Year 4 (2011) 580
Year 5 (2012) 600
The number projected for year 1 is sufficient to continue providing waiver services to all of the eligible individuals on the Autism Waiver as of December 31, 2007.

APPENDIX C-1/C-3 and APPENDIX J

Indiana is deleting the Applied Behavioral Analysis (ABA) service from this renewal application. To date, no waiver participant has utilized this service. Indiana is working in collaboration with advocates and providers to develop a more functional waiver service to replace the current ABA service. The revised service will be submitted in a future amendment to this waiver. The ABA service has been deleted from the renewal document:
Appendix C-1a. Waiver Services Summary,
Appendix C-1/C-3 Service Specifications, and from
Appendix J Cost Neutrality Demonstration.

This renewal also includes the following minor changes:

APPENDIX B-3-F: Selection of Entrants to the Waiver
Language has been added to prohibit a participant on the Autism Waiver from being served under more than one 1915(c) HCBS Waiver program at the same time.

APPENDIX C-1/C-3: Summary of Services Covered/Service Specification

Therapy Services:
The CMS approved Autism Waiver refers to "Therapy Services (Psychological Services)". Therapy Services is re-titled as "Psychological Services" in the renewal application. This is merely a clarification in service title, not a change in the service definition or provider qualifications.

Environmental Modifications:
Clarification has been added to the Environmental Modifications service. Allowable activities include modification to an existing bathroom; adaptations to service provider owned housing is not allowed; and maintenance and repair is limited to the maintenance and repair of modifications that were funded by a waiver service.

Specialized Medical Equipment and Supplies:
Clarification has been added to the Specialized Medical Equipment and Supplies. Vehicle modifications are subject to a $15,000.00 lifetime cap; and maintenance and repair is limited to the maintenance and repair of vehicle modifications or specialized medical equipment that was funded by a waiver service.

Additions to Service Standards:
Indiana has also added waiver Service Standards and Documentation Standards to the service definitions for clarification of Indiana's expectations regarding the provision of these services. The base service definitions have not been changed.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Indiana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Autism Waiver

C. **Type of Request: renewal**

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

Base Waiver Number: 4151

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)* 01/01/90

Waiver Number: IN.4151.R04.00
Draft ID: IN.01.04.00

Renewal Number: 04

D. **Type of Waiver** *(select only one)*:
Regular Waiver

E. **Proposed Effective Date:** *(mm/dd/yy)*
01/01/08

Approved Effective Date: 01/01/08

1. Request Information (2 of 3)

F. **Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

Hospital as defined in 42 CFR §440.10
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:
Not applicable

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program authorized under §1115 of the Act.

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
PURPOSE: The Autism Waiver maximizes available Indiana resources by providing home and community-based services to individuals who, but for the provision of such services, would require Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR) level of care, the cost of which could be reimbursed under the approved Medicaid

State plan. A waiver of section 1902(a)(10)(B) of the Social Security Act is requested to target waiver services to the select group of individuals who are developmentally disabled, with the additional targeting restriction of a diagnosis of Autism Spectrum Disorder (includes Autism, Asperger's syndrome, and Other Pervasive Developmental Disorders).

GOAL: To provide opportunities for meaningful and necessary services and supports, to respect the person's personal beliefs and customs, and to ensure that services are cost effective by assisting the person to become involved in the community where he/she lives and works, to develop social relationships in the person's home and work communities, to develop skills to make decisions about how and where the person wants to live, and to be as independent as possible.

OBJECTIVE: To enable eligible Indiana residents having an Autism Spectrum Diagnosis to be served under the Autism Waiver by refilling vacated slots after the end of each waiver year by targeting the corresponding number of person(s) next in line for services from the statewide, first come, first served Autism Waiver waiting list. Indiana also projects transitioning up to 8 eligible individuals from 100% state funded budgets onto the waiver during the five-year renewal.

Additionally, this waiver will serve 35 new individuals during the first waiver year of the renewal and 50 new individuals in each subsequent waiver year by targeting from the statewide, first come, first served Autism Waiver waiting list until the total number of individuals served reaches 600 by the fifth year of this renewal.

During the first waiver year of the renewal (01/01/2008 to 12/31/2008), we are projecting 35 new individuals will be added, bringing the total to:
430 individuals by 12/31/2008.
During each of the waiver years two through four of the renewal, 50 new persons per waiver year will be served, bringing the totals to:
480 individuals by 12/31/2009,
530 individuals by 12/31/2010, and
580 individuals by 12/31/2011.
During waiver year five of the renewal, 20 new individuals will be served, bringing the total to 600 by 12/31/2012.

ORGANIZATIONAL STRUCTURE: While Indiana's Family and Social Services Administration's Office of Medicaid Policy and Planning (OMPP) is the single state agency having administrative discretion in the administration and supervision of the waiver, issuing policies, rules and regulations related to the waiver, the Division of Disability and Rehabilitative Services (DDRS) is responsible for the day-to-day operations utilizing the Bureau of Developmental Disabilities Services (BDDS) and the Bureau of Quality Improvement Services (BQIS) toward that end.

The BDDS Field Offices are responsible for the intake of each participant into the state system, completing applications for services, determining whether or not each individual meets the state's definition of having a developmental disability (DD), and whether or not the individual meets ICF/MR Level of Care. The BDDS Service Coordinator enters each name into the state database, placing the name on the waiting list(s) for waiver services unless the individual meets the criteria for assignment of a priority slot, as described in Appendix B-3-c.

Once the individual is targeted for a waiver, the Service Coordinator first updates information to verify DD eligibility and Level of Care are met, then refers the person to the contracting entity performing Case Management functions, currently the Indiana Professional Management Group (IPMG). The Case Manager (CM) is responsible for the Person Centered Planning Process, assisting the individual to identify members of the Individualized Support Team, and developing an Individualized Support Plan prior to developing and submitting the plan of care, known as the Plan of Care/Cost Comparison Budget (CCB). The CM also assists the individual in obtaining the required eligibility status under Indiana Medicaid or verifies that the individual already has the correct status.

The contracting Case Management entity is responsible for monitoring timelines for submission of annual CCBs, for the annual renewal of Level of Care determinations, 90-day quarterly reviews, and compliance with DDRS, BDDS and BQIS policy and procedure.

The BDDS Central Office Waiver Unit reviews each Initial CCB, Annual, and Update CCB, issuing decisions via a Notice of Action (NOA) to the Case Manager and all providers of waiver services. The Case Manager must provide a copy of the NOA to the individual and/or the individual's legal guardian.

The BQIS is responsible for the development and implementation of quality improvement and quality assurance initiatives, including Incident Reporting, Standards Surveying, QA committee structure and Complaints/Investigations.

SERVICE DELIVERY METHODS: Traditional service delivery methods will be utilized while incorporating as much flexibility as possible within the delivery of services through the application of the Objective Assessment System for

Individual Supports (OASIS). Prospective providers must attend a provider orientation before obtaining an application and submitting a proposal to become an approved waiver provider. Providers of waiver services must be enrolled as BDDS approved providers with the state's Medicaid system, Indiana Health Coverage Programs prior to being authorized to provide waiver services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. Appendix H contains the Quality Management Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (•) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
  Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
  Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Public input regarding Indiana's waiver program, including the Autism Waiver is obtained through the following activities. Input is not limited to the waiver renewal, but is encouraged throughout the year for continuing input to the State.

The Division of Disability, Rehabilitative Services (DDRS) Executive Management Team holds twice-monthly meetings with the “Advocates”, an organized group consisting of leaders among the service providers (Indiana Association of Rehabilitation Facilities, Inc "INARF"), the case management provider (Indiana Professional Management Group, known as IPMG), behavioral clinicians (Indiana Association of Behavioral Consultants "IN-ABC"), and advocates (Arc of Indiana) addressing concerns and suggestions on behalf of the group and the individuals each represents in regard to DDRS program policy and operations.

The Bureau of Developmental Disability Services (BDDS) hosts quarterly provider meetings within each of its eight statewide districts during which concerns of providers and/or waiver participants may be presented. Additional meetings are held as needed, such as when new initiatives are introduced. District Office personnel are sometime invited to attend meetings with individual providers.

The DDRS issues quarterly policy bulletins in a draft format inviting public feedback during a 30-day comment period prior to finalization.

The BDDS maintains an electronic helpline available 24 hours daily and serving not only as a source of answering questions but also as a receptor of suggestions and ideas from any interested party. Responses are issued within one working day of receipt as one BDDS staff member is dedicated to receiving requests and issuing feedback.

The Bureau of Quality Improvement Services (BQIS) conducts approximately 2100 consumer satisfaction surveys annually using the Core Indicator Project form.

The Quality Improvement Executive Committee (QIEC) meets monthly with a family member and quarterly with all

interested providers, self-advocates and other family members to discuss quality assurance and improvement measures, to receive reports and recommendations from the Mortality Review, Sanctions and Risk Management Committees, to identify trends, and to begin the development of new policy when needed.

The DDRS has a contractual agreement with "Briljent" to hold public forums on an as needed basis toward the dissemination of program or operational changes surrounding the Objective Assessment System for Individual Supports (OASIS) system as it currently exists as well as toward desired changes. Significant emphasis is being placed upon gathering stakeholder input during the shadowing and piloting processes toward the creation of a uniform rate model and an individual budget process that meets the needs of the individuals Indiana serves and the providers that serve them.

Effective July 1, 2007 through June 30, 2009, the DDRS has contracted with the Arc of Indiana to serve as an extension of the Division. The Arc of Indiana shall employ ten "self-advocates" as well as ten "family advocates" (family members) from among the total population of individuals with developmental disabilities served within Indiana. The Arc of Indiana in conjunction with DDRS will first educate and train each advocate before forming teams composed of advocates, Arc personnel, and state staff within each of the eight BDDS Districts. The teams will focus on the provision of statewide support to both consumers and family members as they conduct a variety of training, development, outreach, assistance, promotion and follow up tasks (specified within the contract) in addition to measuring customer satisfaction through surveys. Monthly and quarterly reporting requirements are specified within the contract.

The DDRS hosts a monthly DDRS Advisory Council meeting as established within IC 12-9-4. The Council consists of the Director of DDRS and ten other individuals, with knowledge of or interest in the programs administered by the Division, who are appointed by the Secretary of the Indiana Family and Social Services Administration. The appointed individuals represent a wide and diverse membership including providers, parents, self-advocates, the Department of Education, and the Office of Medicaid Policy and Planning, as well as other Bureaus within the Division; including First Steps, Vocational Rehabilitation, and the Bureau of Quality Improvement Services. The mission of the DDRS Advisory Council is to recommend strategies and actions that will ensure DDRS empowers people with disabilities to be independent and self-sufficient.

The DDRS has a contractual agreement with the Autism Coalition and the Autism Society of Indiana to ensure Indiana maintains a comprehensive plan for serving individuals of all ages with autism. Each entity participates in the renewal process by providing input and recommendations during scheduled meetings with the DDRS.

The DDRS regularly communicates with the fourteen, diversified political party members of the Indiana Commission on Autism (established within Indiana Code 12-11-7 toward the study and oversight of the service delivery system within Indiana as it pertains to individuals with autism). The Commission provides feedback to the DDRS toward ensuring that DDRS is meeting state regulations to support this population.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Fairman

First Name: Korryn

Title:

Program Director 1

Agency: Indiana Family & Social Services Administration, Office of Medicaid Policy & Planning

Address: 402 W. Washington Street, Room W374 (MS 07)

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204-2739

Phone: (317) 232-4346 **Ext:** ☐ **TTY**

Fax: (317) 232-7382

E-mail: Korryn.Fairman@fssa.in.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Shields

First Name: Adrienne

Title: Chief of Staff

Agency: Indiana Family & Social Services Administration, Division of Disability and Rehabilitative Services

Address: 402 W. Washington Street, Room W451 (MS 26), PO Box 7083

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46207-7083

Phone: (317) 232-1147 **Ext:** ☐ **TTY**

Fax: (317) 232-1240

E-mail: Adrienne.Shields@fssa.in.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Jeff Wells

State Medicaid Director or Designee

Submission Date: Dec 12, 2007

Last Name:

	Wells
First Name:	Jeffrey
Title:	Director of Medicaid
Agency:	Indiana Family & Social Services Administration, Office of Medicaid Policy & Planning
Address:	402 W. Washington Street, Room W374 (MS 07)
Address 2:	
City:	Indianapolis
State:	**Indiana**
Zip:	46204-2739
Phone:	(317) 234-2407
Fax:	(317) 232-7382
E-mail:	Jeffrey.Wells@fssa.in.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable for this renewal

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one: do not complete Item A-2)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the unit name:

   Do not complete item A-2.

   ◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the unit name:
   Indiana Family & Social Services Administration, Division of Disability and Rehabilitative Services

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*

Appendix A: Waiver Administration and Operation

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The waiver will be operated by the Indiana Division of Disability and Rehabilitative Services (DDRS), a separate division of the state from the Single State agency, the Indiana Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP). The OMPP exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the Memorandum of Understanding setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

The oversight role of the Medicaid agency toward ensuring that the operating agency performs its assigned operational and administrative functions in accordance with waiver requirements of Medicaid fiscal and quality accountability and audits for developmentally disabled services is as follows:
• Annually, OMPP shall supervise the development of the CMS annual waiver expenditure reports, review the final report with DDRS and identify problem areas that may need to be discussed and resolved with DDRS prior to submission by OMPP.
• Monthly, OMPP shall review Medicaid waiver expenditure reports, after which, any identified problems will be discussed and resolved with DDRS.
• Daily, OMPP, or OMPP's Fiscal Intermediary, shall review, approve and assure payment of Medicaid claims for waiver services consistent with OMPP established policy.
• Ongoing, OMPP shall be responsible for oversight of all waiver activity (including the contract for case management, level of care (LOC) determination, plan of care reviews, identification of trends and outcomes, and initiating action to achieve desired outcomes) retaining final authority for approval of level of care and plans of care.

• OMPP shall develop and coordinate Medicaid policy for the State of Indiana
• OMPP, or OMPP's Fiscal Intermediary, shall approve and enroll all providers of waiver services
• OMPP shall review and approve Medicaid waiver applications, requests for renewals and amendments, and shall submit applications, renewals and amendments to the United States Department of Health and Human Services to fund community and home based developmental disability services as alternatives to institutionalization.
• OMPP shall seek and review comment from DDRS before the adoption of rules or standards that may affect the services, programs, or providers of medical assistance services for persons with developmental disabilities who receive Medicaid services.
• OMPP will review and approve all waiver manuals, bulletins, communications regarding waiver policy, and quality assurance/improvement plans prior to implementation or release to providers, participant families or any other entity.

• OMPP shall retain final authority for rate setting and coverage criteria for all Medicaid services, including provider rates, the basis for any activities reimbursed through administrative funds, and state plan services provided to waiver participants.

Management teams from OMPP and DDRS meet every other week to review programs, recommend changes and address programming concerns. The performance of contracting entities is reviewed, discussed and addressed as needed during these meetings. Management teams from OMPP and DDRS meet every other week. The executive office of the Family and Social Services Administration is also represented at these meetings where programs are reviewed, changes are recommended, programming concerns are addressed and the performance of contracting entities is reviewed, discussed and addressed as needed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative

functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

1. DISSEMINATE INFORMATION CONCERNING THE WAIVER:
Case Management services are contracted to the Indiana Professional Management Group (IPMG) for all participants served under the Autism Waiver. The Case Manager provides the individual with information about the Autism Waiver once a targeted individual has been determined by the operating agency to have a developmental disability and to meet federal criteria for admission into an Intermediate Care Facility for the Mentally Retarded. It is only after the state and federal criteria are met that the potential enrollee is referred to IPMG. Information is disseminated by IPMG via phone calls as well as face-to-face meetings with the individual and the Individualized Support Team.

2. ASSIST INDIVIDUALS IN WAIVER ENROLLMENT:
Case Management services assist eligible individuals who have been referred by the operating agency to obtain or otherwise update Medicaid eligibility status as is necessary for participation in the waiver program.

3. CONDUCT UTILIZATION MANAGEMENT FUNCTIONS:
A. The Case Manager monitors each participant for quality of services and effectiveness of the Individualized Support Plan (ISP) outcomes. This is monitored by documented face-to-face review between the participant and the case manager every 90 days. If the participant's Individualized Support Plan (ISP) requires more than one face-to-face review every 90 days, then the participant's ISP shall govern the number of contacts case manager must make with such a participant. The IPMG Case Manager assures that services have been authorized in conformance to waiver requirements and monitors service utilization to ensure that services have been authorized and that the amount of service is within the levels authorized within the service plan known as the Plan of Care/Cost Comparison Budget (CCB). The IPMG Case Manager will contact the provider and, if necessary, file an incident report through the Bureau of Quality Improvement Services when it is discovered that a participant is not receiving authorized services or when the amount of services utilized is substantially less than the amount authorized on the CCB, which may indicate potential problems with service access. IPMG maintains a 24-hour per day emergency response system that does not rely upon the area 911 system and provides information and assistance to all participants.

Throughout these activities, Case Management services assist those participants who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Other related responsibilities of the Case Manager include monitoring of services; face to face contacts between the Case Manager and the participant; coordinating facilitation of the Person Centered Planning (PCP) process; developing, updating and reviewing the Individualized Support Plan (ISP); facilitating completion of the annual waiver requirements for level of care re-determination and annual review/update of the PCP and ISP; annual submission of the waiver budget; disseminating information and forms to the participant and the participant's IST; incident reporting and follow up; monitoring participant satisfaction and service outcomes; monitoring claims for payment of services; file documentation and maintenance; acting as an agent for the participant; and negotiating the best solutions, resource identification and other participant or system needs.

B. Waiver auditing will be incorporated into the Surveillance Utilization Review (SUR)functions of a contract negotiated between the Medicaid agency and selected contractor. Implementation is expected to occur during 2008, the first year of the Autism Waiver Renewal.

The selected contractor will construct an audit process that utilizes data mining, research, identification of outliers, problem billing patterns, aberrant providrs, and those referred by the state. The participant's eligibility for waiver services will be validated. Home visits will be conducted to verify that services billed are authorized in the plan of care, are being delivered, and are meeting the needs of the participant. The OMPP will oversee the contractor's aggregate data to identify common problems, determine benchmarks, and can provide data to providers to compare against aggregate data. A major focus of the audit exit process will be provider education.

4. EXECUTE THE MEDICAID PROVIDER AGREEMENT:
The Medicaid agency has a fiscal agent under contract which is obligated to process the Medicaid Provider Agreements to enroll approved eligible providers in the Medicaid Management Information System for claims

processing. This includes the approved Autism Waiver providers. The contract defines the roles and responsibilities of the Medicaid Fiscal Contractor.

5. CONDUCT TRAINING AND TECHNICAL ASSISTANCE CONCERNING WAIVER REQUIREMENTS:
The contracted case management entity, IPMG, provides training to all Case Managers serving participants under the Autism Waiver. All training curriculums must first be approved by the operating agency and focus on best practices in each aspect of the service plan development, including the Person Centered Planning process, the development of the Individualized Support Plan (ISP), and development of the Plan of Care/Cost Comparison Budget.

The IPMG is familiar with waiver service and documentation requirements and is capable of assisting a provider in obtaining or referencing relevant policy or policies issued by the Medicaid agency and the operating agency. The IPMG works with the Medicaid agency and the operating agency to implement systemic and policy changes toward improving waiver operations.

- **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- **Not applicable**
- **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

    Specify the nature of these agencies and complete items A-5 and A-6:
  - **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

    Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
1. The Division of Disability and Rehabilitative Services (DDRS) Case Management Liaison position is responsible

for monitoring and assessing the performance of the contracted case management entity, Indiana Professional Management Group, Inc.(IPMG).

2. The Office of Medicaid Policy and Planning (OMPP), will be responsible for oversight of waiver audit functions performed by the Surveillance and Utilization Review (SUR) contractor to be selected during 2008, the first year of the Autism Waiver Renewal.

OMPP, in collaboration with DDRS, is responsible for assessing the execution of the Medicaid Provider Agreements toward the enrollment of Autism Waiver providers approved by DDRS.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
1. DISSEMINATE INFORMATION CONCERNING THE WAIVER:
Indiana Professional Management Group (IPMG) is required to comply with all reporting requirements of the State. Reporting and communication between IPMG and the Indiana Family and Social Services Administration's Division of Disability and Rehabilitative Services (DDRS) is managed through the DDRS Case Management Liaison position. The IPMG Case Manager documents within Case Notes each contact with the individual and the topics of discussion as they occurred during the contact. These notes are subject to review by DDRS Case Manager Liaison. The DDRS Case Management Liaison position conducts on-site operational review at least annually or more often when circumstances dictate a need, ensuring that potential enrollees have been advised about the waiver. Twice yearly, the Liaison also examines results of participant satisfaction surveys to ensure each individual is adequately informed about the waiver.

2. ASSIST INDIVIDUALS IN WAIVER ENROLLMENT: The DDRS Case Management Liaison performs weekly reviews of performance data submitted by IMPG to assure IMPG responds in a timely manner to referrals of eligible participants received from the Bureau of Developmental Disabilities Services (BDDS) District Office. The IPMG is expected to make contact with the individual within 30 days of the referral. The liaison position will also review on a twice yearly basis, the results of participant satisfaction surveys regarding the waiver enrollment process.

Issues and concerns with the performance of IPMG are addressed during operations meetings with State representatives which are scheduled to occur every other week. During these meetings, the DDRS is represented by the DDRS Case Management Liaison, the DDRS Chief of Staff and the Director of Client Services. The IPMG is represented by the Managing Director, each of 6 Case Management Organization Regional Directors (CMOs), the Director of Intake & Assessment and the Director of Finance. IPMG is also represented at the Advocates meeting which occurs twice monthly as well as the Quality Improvement Executive Committee (QIEC) which meets quarterly. Herein, additional performance concerns may be addressed as needed.

The IPMG notifies the DDRS at the end of each month the number of participants served, number of full-time equivalent case managers and average caseload per full-time equivalent case manager. The IPMG also reports the number of case managers employed by IPMG, number of case managers per IPMG district, the number of new case managers, the number of case managers that terminated employment relationship with IPMG, the number of case management changes for participants (i.e choice), the number of participants per case manager, the time frame for the entire IPMG intake process, written identification of all information technology authorized to communicate with State Department of Technology. Through the review of these reports, the DDRS Case Management Liaison in conjunction with the DDRS Executive Management Committee is able to determine whether or not IPMG is capable of fulfilling the requirements and deliverables of the existing contract.

3. CONDUCT UTILIZATION MANAGEMENT FUNCTIONS:
A. In order to assure that the contracting entity is satisfying the utilization management functions outlined in the contract with the state, IPMG solicits a Consumer/Family Satisfaction Survey at least semi-annually for each Autism Waiver participant and a provider satisfaction survey at least annually. The surveys are reviewed and approved by

the DDRS and the Office of Medicaid Policy and Planning (OMPP). Results of findings and documentation of efforts to improve the delivery of services will be sent to the DDRS twice yearly for review by the DDRS Case Management Liaison and the DDRS Executive Management Committee. Additional information regarding the DDRS Quality Management Strategy is available in the Appendix H.

IPMG prepares and submits Quarterly Summary reports for individual/participants served.
Through the review of these reports, the DDRS Case Management Liaison, in conjunction with the DDRS Executive Management Committee, is able to determine whether or not IPMG is capable of fulfilling the requirements and deliverables of the existing contract.

B. In order to assure that the contracting entity selected to perform waiver auditing functions under the Surveillance Utilization Review (SUR) contract negotiated by OMPP is satisfying conditions of the contract, OMPP will exercise oversight and monitoring of the deliverables stipulated within that contract. Reporting requirements will be determined as agreed upon within the fully executed contract, which is expected to be implemented during the year 2008, the first year of the Autism Waiver Renewal.

4. EXECUTE PROVIDER AGREEMENT:
The Division of Disability and Rehabilitative Services (DDRS) Provider Relations Specialist oversees and assures that providers are appropriately enrolled through the Medicaid fiscal agent. The required Waiver Enrollments and Updates Weekly Report is sent by the fiscal agent to the DDRS Provider Relations Specialist. Providers are to be enrolled by the dedicated fiscal agent Provider Enrollment Specialist within an average 30 days from receipt of the completed provider agreement paperwork. Complaints about the timeliness or performance of the Medicaid fiscal agent are relayed to the OMPP Director of Operations and Systems by the DDRS Provider Relations Specialist.

5. CONDUCT TRAINING AND TECHNICAL ASSISTANCE CONCERNING WAIVER REQUIREMENTS:
Any training curriculum utilized by IPMG will be reviewed and approved by the Medicaid agency and the operating agency prior to presentation. The DDRS Case Management Liaison personally attends at least one IPMG training session presentation covering each new waiver policy or procedural change. The Liaison ensures that the training presentation is an accurate portrayal of current policy and procedure.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Disseminate information concerning the waiver to potential enrollees	☐	☑	☑
Assist individuals in waiver enrollment	☑	☑	☑
Manage waiver enrollment against approved limits	☑	☑	☐
Monitor waiver expenditures against approved levels	☑	☑	☐
Conduct level of care evaluation activities	☑	☑	☐
Review participant service plans to ensure that waiver requirements are met	☑	☑	☐
Perform prior authorization of waiver services	☑	☑	☐
Conduct utilization management functions	☐	☑	☑
Recruit providers	☐	☑	☐
Execute the Medicaid provider agreement	☑	☐	☐
Determine waiver payment amounts or rates	☑	☑	☐

Conduct training and technical assistance concerning waiver requirements	☑	☑	☑

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
◉ **Mental Retardation or Developmental Disability, or Both**					
	☑	**Autism**	0		☑
	☑	**Developmental Disability**	0		☑
	☐	**Mental Retardation**			☐
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

The participant will have a diagnosis of Autism Spectrum Disorder qualifying as a Developmental Disability as is defined by the Developmental Disablities Assistance and Bill of Rights Act of 2000 [P.L. 106-402, 42 USC 15002 (8)(A)&(B)].

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

- **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - **Other**

    Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	430
Year 2	480
Year 3	530
Year 4 (renewal only)	580
Year 5 (renewal only)	600

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ( ) **Not applicable. The state does not reserve capacity.**
- (●) **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes
Eligible individuals transitioning off of 100% state funded budgets

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Eligible individuals transitioning off of 100% state funded budgets

Purpose *(describe):*

PURPOSE: To prioritize waiver access to individuals who are developmentally disabled with a diagnosis of Autism Spectrum Disorder and are transitioning off of 100% state funded budgets in order to maximize the use of state dollars and the total number of eligible individuals who may be served.

Describe how the amount of reserved capacity was determined:

In the five year renewal period, the state will reserve capacity for eight individuals to transition from 100% state funded budgets to the Autism Waiver. The reserved capacity for eight persons to make this transition was determined in the following manner:

• Using the state's case management automated data system, Developmental Disabilities Automated Resources Tool (known as DART), used for tracking the status of all individuals who apply for state funded and/or waiver services on the basis of having a developmental disability, a report was generated containing the names and service settings (e.g. waiver, supervised group living, nursing facility, etc.) of individuals receiving services through BDDS in order to determine how many were receiving 100% state funded services.

• Although the actual numbers vary as individuals come in and out of services throughout the month, the report indicated there were approximately 920 individuals previously determined by the state as having a condition satisfying the eligibility requirements for a developmental disability as is defined by the Developmental Disablities Assistance and Bill of Rights Act of 2000 [P.L. 106-402, 42 USC 15002(8)(A)&(B)] and being served exclusively through 100% state funded budgets during the month of September 2007.

• Based upon statistics released by the Indiana Resource Center for Autism (IRCA) via their 2007 publication of the "Reporter" (Volume 12, Number 3) the incidence of Autism is estimated to occur in one of every 150 individuals. Using these statistical guidelines, it was estimated that six of the 920 individuals receiving 100% state funded budgets/services may have a diagnosis of Autism Spectrum Disorder. [Note that the IRCA is affiliated with Indiana's University Center for Excellence on Disabilities and the Indiana Institute on Disability and Community in Bloomington, Indiana.]

• Of those six individuals, it was estimated that one person would fail to meet the required criteria for ICF/MR Level of Care through the process explained within Appendix B-6-d.

• It was further estimated that three of the remaining five individuals would be found eligible to transition from 100% state funded budgets to the Autism Waiver during the first year of the Autism Waiver Renewal with two more eligible individuals transitioning during year two of the waiver.

• Finally, it was estimated that, during each subsequent year of the waiver (years three, four and five of the Renewal), due to a crisis or other emergency situation, approximately one additional person with a diagnosis of Autism Spectrum Disorder would begin receiving immediate/emergency services under a 100% state funded budget with the potential for meeting state and federal eligibility criteria toward transitioning to the Autism Waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	3
Year 2	2
Year 3	1
Year 4 (renewal only)	1
Year 5 (renewal only)	1

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (•) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (•) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

With the exception of individuals meeting priority criteria noted in Appendix B-3-c, entrance to the Autism Waiver is governed on a first come/first served basis by the applicant's signed and dated application for waiver services.

The applicant or legal representative is asked to sign the STATEMENT FOR FREEDOM OF CHOICE form [State Form 46016 (R8/4-02)/HCBS 0003] described under Appendix B-7. If the QMRP Intake Service Coordinator (serving as an Intake Case Manager) determines that the individual does meet ICF/MR level of care, the individual will be assigned a waiver slot, if one is available. When no slot is available, the individual's name will be placed on the Autism Waiver's single statewide waiting list. Thereafter, the selection (targeting) process toward filling available slots is managed on a first come, first served basis, using the date of application for Autism Waiver services following the Bureau of Developmental Disabilities' Targeting Process for DD Eligible Individuals Under ICF/MR Level of Care Waivers.

Individuals being served under any other 1915(c) home and community-based services waiver shall not be concurrently served under the Autism Waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

- ○ **§1634 State**
- ○ **SSI Criteria State**
- ◉ **209(b) State**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☑ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☑ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage: [ ]

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy**
- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

[ ]

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based**

waiver group under 42 CFR §435.217. *Appendix B-5 is not submitted.*

- (●) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

  - ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
  - (●) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

    Check each that applies:

    - [x] **A special income level equal to:**

      Select one:

      - (●) **300% of the SSI Federal Benefit Rate (FBR)**
      - ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

        Specify percentage:
      - ( ) **A dollar amount which is lower than 300%.**

        Specify dollar amount:
    - [x] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
    - [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
    - [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
    - [ ] **Aged and disabled individuals who have income at:**

      Select one:

      - ( ) **100% of FPL**
      - ( ) **% of FPL, which is lower than 100%.**

        Specify percentage amount:
    - [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

      Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to

individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-c (209b State) and Item B-5-d)
  - **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-c (209b State) . Do not complete Item B-5-d)
- **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-c (209b State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- **The following standard included under the State plan**

  (*select one*):

  - **The following standard under 42 CFR §435.121**

    Specify:

- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**

(*select one*):

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of the FBR, which is less than 300%**

Specify percentage:

- **A dollar amount which is less than 300%.**

Specify dollar amount:

- **A percentage of the Federal poverty level**

Specify percentage:

- **Other**

Specify:

- **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- **The following formula is used to determine the needs allowance:**

Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable (see instructions)**
- **The following standard under 42 CFR §435.121**

Specify:

- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Subtract the maximum Federal Benefit Rate (FBR) for an individual from the maximum FBR for a couple.

iii. Allowance for the family (*select one*):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other
Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

Initial Level of Care evaluations are performed by the Bureau of Developmental Disabilities Services (BDDS) Service Coordinator employed by the operating agency specified in Appendix A, with the following exceptions: 1) the individual targeted for waiver services is age 5 or younger, or 2) the individual is currently a resident of

an ICF/MR facility and has been cited by the Indiana State Department of Health with a W-198 or W-197 tag. Under these exceptions, the level of care determination is made by the BDDS Level of Care Unit, also employed by the operating agency specified in Appendix A.

Reevaluations are performed by the Indiana Professional Management Group, Inc. (IPMG), the contracting entity of case management services.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Only state employees who are qualified as Qualified Mental Retardation Professionals (QMRP) as specified by the standard within 42 CFR 483.430(a) may perform initial Level of Care determinations.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

To complete a level of care determination, the BDDS Intake Service Coordinator (for initial determinations) or contracted Intake and Assessment Specialist (case manager)(for reevaluations) must obtain and review the following:

1) Psychological records including I.Q. score;
2) Social assessment records;
3) Medical records;
4) Additional records necessary to have a current and valid reflection of the individual;
5) A completed Medicaid Form 450B medical form, signed and dated by a physician within the past year.

If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained through the local BDDS-contracted Diagnosis and Evaluation (D&E) team. The D&E teams are contracted through the Bureau of Developmental Disabilities Services. The Teams include psychologists, physicians, nurses and licensed social workers.

In addition to reviewing the collateral records, the QMRP Intake Case Manager/Service Coordinator must perform a Developmental Disabilities Profile (DDP), applicable to individuals with mental retardation and other related conditions. Additional information regarding administration of the DDP and the DDP for Children is found in Appendix D-1-d.

The DDP assessment tool:
• collects and considers the vocational programs of applicant/participant
• identifies all developmental disabilities applicable to the applicant/participant as well as any psychiatric diagnosis and results of the individual's intellectual assessment
• reports status of hearing and vision
• identifies the alleged perpetration of crimes committed by the applicant/participant as well as the need for police involvement for maladaptive behaviors
• identifies barriers which hinder the achievement of personal independence, productivity, integration and community inclusion as well as barriers which hinder achieving the identified lifestyle and related needs
• identifies significant medical conditions requiring specialized medical supports or impacting the participation in services
• looks at the utilization and frequency of health-related services including the identification and detailing of issues within the respiratory, cardiovascular, gastro-intestinal and genito-urinary systems, and any evidence of neoplastic or neurological diseases
• identifies any seizures by type, frequency and required medications
• identifies medication support needs and medical consequences related to the above conditions
• addresses mobility issues, motor control, cognitive and communication abilities
• assesses the frequency and consequences of behaviors
• examines self care and activities of daily living support needs
• determines the need for and frequency of utilization of clinical services

When the DDP pertains to a child who is age 6 but not yet age 11, the DDP Children's Assessment is administered. As noted in Appendix B-6-b, exceptions regarding the bearer of responsibility for determining Level

of Care for children under age 6 as well as for individuals who live in a facility and are cited with a W-197 or W-198 tag by the Indiana State Department of Health (ISDH) is deferred to the BDDS Level of Care Unit.

The Intake Service Coordinator or Case Manager reviews the DDP and collateral material, including the report of an independent assessment organization, if available. To meet level of care, an applicant/participant must receive a score of 28 or higher on the DDP and meet each of four basic qualifications and three of six substantial functional limitations.

The basic qualifications are: 1) mental retardation, cerebral palsy, epilepsy, autism, or condition similar to mental retardation, 2) the condition identified in #1 is expected to continue, 3) the condition identified in #1 had an age of onset prior to age 22, and 4) the applicant needs a combination or sequence of services.

The substantial functional limitation categories, as defined in 42 CFR 435.1009, are: 1) self-care, 2) learning, 3) self-direction, 4) capacity for independent living, 5) receptive and expressive language, and 6) mobility.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The DDP, fully described in Appendix B-6-d, is the required intrument to be used in determining waiver level of care. The DDP is used in addition to the collateral information that is required to be used for institutional level of care determination.

The Intake Service Coordinator (for initial evaluations) or contracted waiver Case Manager (for reevaluations) reviews the DDP and collateral material, including the report of an independent assessment organization, if available. To meet waiver level of care, an applicant/participant must receive a score of 28 or higher on the DDP and meet each of four basic qualifications and three of six substantial functional limitations.

The use of the DDP is not required in determining institutional level of care.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The level of care initial evaluation process is described in Appendix B-6-d and is performed by a BDDS Intake Service Coordinator.

The process for reevaluation of level of care is the same as the initial evaluation, but it is performed by the contracted waiver Case Manager as opposed to the BDDS Intake Service Coordinator. Indiana Professional Management Group (IPMG) is the centralized case management organization contracted by the Indiana Family and Social Services Administration (FSSA).

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**
  Specify the other schedule:

Level of care reevaluations are required for each participant at least every twelve months. Level of care reevaluations will also be completed when there is significant change in the individual's health or cicumstances.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform**

initial evaluations.

The qualifications are different.
Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The state's electronic case management data system (named the INsite program) allows case managers to run reports which will provide timely notification of the need for Level of Care (LOC) redeterminations for each recipient. DDRS staff will also be alerted to LOC evaluations near expiration through the periodic reports generated by INsite and will follow-up with case managers to assure redeteminations are completed and the LOC date is changed in the system.

Additionally, the contracting case management entity, IPMG utilizes their own internal data system to monitor and track the timeliness of LOC determinations by the case managers they employ.

Note that the state's electronic case management data system (INsite) is programmed so that it does not permit the state's approval of a service plan (described in Appendix D) for which the level of care determination or redetermination has not been made within the past 12 months.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are maintained by the operating agency's Bureau of Developmental Disabilities Services office within the electronic case management data system (INsite) and are retrievable indefinitely upon request. These records are maintained for a minimum of 3 years.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

During the initial application for services process referenced under the Application (Module 1), the Bureau of Developmental Disabilities Services (BDDS) Intake Service Coordinator, serving in the role of a Medicaid Waiver Case Manager, is responsible for informing the applicant and/or his or her legal representative, if applicable, of the feasible alternatives available under the waiver. This activity will occur when it is determined that the applicant is an individual who, but for the provision of such services, would likely require the Intermediate Care Facility for the Mentally Retarded or persons with related conditions (ICF/MR) level of care, the cost of which could be reimbursed under the approved Medicaid State plan.

The applicant or legal representative is asked to sign the STATEMENT FOR FREEDOM OF CHOICE form [State Form 46016 (R8/4-02)/HCBS 0003] described below.

Once an applicant is determined to meet state and federal eligibility criteria referenced in Appendix D of this application, the applicant is referred to the contracting case management entity, Indiana Professional Management

Group, Inc. (IPMG).

Note: The Intake & Assessment Specialist employed by IPMG presents the participant or legal representative with a Choice List (pick list) during the initial Intake meeting toward the selection of a Case Manager. The IPMG District Supervisor or Special Projects Manager follows up with the applicant or legal representative shortly thereafter to coordinate interviews. When the participant or legal representative chooses a Case Manager, a Choice Statement is signed, dated and electronically stored in the IPMG database as well as in the participant's file. If the participant or legal representative does not find a suitable Case Manager among the choices presented, the Special Projects Manager provides interim case management services and additional interview opportunities until a Case Manager is chosen.

Following the selection of a Case Manager and through the development of the initial service plan (referenced within the Application (Module 1) and Appendix A, Item 3 of this application), the IPMG Case Manager is responsible for informing the applicant or legal representative, if applicable, of the feasible alternatives available under the waiver. The participant verifies that this information has been presented to them by signing Section I of the Plan of Care/Cost Comparison Budget described below. At least annually, and any time a new service plan is required, the IPMG Case Manager will review this freedom of choice with the participant.

The applicant or legal representative is asked to sign the STATEMENT FOR FREEDOM OF CHOICE form [State Form 46016 (R8/4-02)/HCBS 0003] described below.

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

DESCRIPTION OF THE FORMS USED TO DOCUMENT FREEDOM OF CHOICE:

• STATEMENT FOR FREEDOM OF CHOICE (State Form 46016-HCBS 0003): Section 1 is completed only by "targeted" HCBS waiver applicants who choose institutional placement. This form is signed and dated by the recipient, the recipient's family/guardian, representative or advocate, and the Medicaid waiver services Case Manager. The Case Manager is responsible for explaining the services available to the individual in an institutional setting as well as the feasible alternatives available under the Medicaid HCBS Waiver Program. The individual is informed that in order to be eligible for the waiver program, the costs of those services may not exceed the costs of institutional care. Section II should only be completed if a "targeted" HCBS Waiver applicant is currently on a Medicaid Managed Care program or if an HCBS Waiver recipient wants to transfer to a Medicaid Managed Care program (if eligible). In Indiana, the programs are mutually exclusive. Individuals who are eligible under 42 CFR 435.217 are only Medicaid eligible if they are receiving home and community-based waiver services. The Medicaid Waiver Case Manager is responsible for explaining this exclusivity and the array of services available under the HCBS Waiver program and the Medicaid Managed Care program.

• Plan of Care/Cost Comparison Budget: is used for only those individuals who choose waiver services. Once an individual is "targeted" for a waiver slot, is Medicaid eligible, and has met Level of Care approval, a Plan of Care/Cost Comparison Budget (POC/CCB) will be developed. The Plan of Care/Cost Comparison Budget (POC/CCB) is used for waiver recipients at the time of initial determinations, updates, and annual re-determinations. A statement regarding freedom of choice is contained in Section I of the form. The waiver recipient/guardian signs and dates this section indicating his/her choice of waiver services or institutional services. The Medicaid Waiver Services Case Manager is responsible for explaining the array of services available in an institutional setting as well as the feasible alternatives available through the Medicaid HCBS Waiver program.

A DESCRIPTION OF THE AGENCY'S PROCEDURE(S) FOR INFORMING ELIGIBLE INDIVIDUALS (OR THEIR LEGAL REPRESENTATIVES) OF THE FEASIBLE ALTERNATIVES AVAILABLE UNDER THE WAIVER:

• It is the responsibility of the Medicaid Waiver Services Case Manager to inform the individual/guardian of the services available in an institutional setting and the array of services available to meet that individual's needs through the Medicaid HCBS Waiver program.

A DESCRIPTION OF THE STATE'S PROCEDURES FOR ALLOWING INDIVIDUALS TO CHOOSE EITHER INSTITUTIONAL OR HOME AND COMMUNITY-BASED SERVICES:

• Eligible individuals are provided with a choice of either institutional or home and community-based services through the use of the STATEMEMT FOR FREEDOM OF CHOICE and the Plan of Care/Cost Comparison Budget

forms. It is the responsibility of the Medicaid Waiver Services Case Manager to fully inform the individual/guardian of the services available in an institutional setting and the array of services available to meet the needs of the individual through the Medicaid HCBS Waiver. After becoming familiar with the alternatives, the individual/guardian is provided the opportunity to decide which option best serves his/her needs. Language contained in both the STATEMENT FOR FREEDOM OF CHOICE and the Plan of Care/Cost Comparison Budget forms verifies that the individual has been fully informed of the services available in the institutional setting and the feasible alternatives under the HCBS Waiver, and that the individual/guardian has made an informed, voluntary choice. Individuals who choose to have their needs met through the Medicaid HCBS Waiver are asked to make an informed choice about the services they want to receive to meet their need, and from which approved provider they want to receive the services.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The initial signed and dated STATEMENT FOR FREEDOM OF CHOICE of Choice form is maintained within the Bureau of Developmental Disabilities Services Field Office having jurisdiction over the individual's county of residence.

All subsequent freedom of choice documentation is maintained by the Case Manager in the client record. The participant's freedom of choice is reviewed with the participant at least annually.

These records are available for a minimum of 3 years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
As an integral part of the operating agency, the Division of Disability and Rehabilitative Services' (DDRS) Bureau of Deaf and Hard of Hearing Services serves as a resource for interpreter services to the deaf and hard of hearing. As needed, the operating agency is able to assist with referrals for sign language interpreters toward the effective communication with applicants or participants, when interpreter services are not already included on the service plan of the participant.

The operating agency relies heavily on the English proficient family members or friends of the applicant/participant to interpret in the native language of the applicant/participant. Staff members of the operating agency sometimes utilize locally available interpreters associated with community or neighborhood organizations and church groups for interpretation of non-English languages. Some metropolitan communities within Indiana offer access to interpreters of varying languages through local colleges, universities or libraries.

The http://www.imcpl.org/cgi-bin/irnget.pl?Interpreters is a website offering connections to Asian, Latino, and American Sign Language interpreters within the Marion County/Indianapolis area as well as the translation of personal documents.

As outlined within the Individualized Support Plan (ISP) and incorporated in the Plan of Care/Cost Comparison Budget (CCB), providers of services are expected to meet the needs of the individuals they serve, inclusive of effectively and efficiently communicating with each participant by whatever means is preferred by the participant. If the participant is a Limited English Proficient (LEP) person, the provider is expected to accommodate those needs during the delivery of any and all services they were chosen to provide.

Recognizing the need to improve access to and availability of interpreters of non-English languages, especially for those less commonly spoken, the operating agency will explore the use of reliable web-based interpreter services which may be employed to translate applications, service plans, freedom of choice statements, Notices of Action, pick lists and other written materials into non-English languages when a significant number or percentage of program participants require information in a particular language other than English.

Assisting the operating agency toward that end, the contracting entity of case management services, Indiana Professional Management Group, Inc. (IMPG) aims to provide bilingual services. It is the goal of IPMG to employ an Intake and Assessment Specialist capable of speaking Spanish fluently and communicating via American Sign Language.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Adult Day Services
Statutory Service	Day Services
Statutory Service	Rent and Food for Unrelated Live-In Caregiver
Statutory Service	Residential Habilitation and Support
Statutory Service	Respite Care
Other Service	Adult Foster Care
Other Service	Behavioral Support Services/Crisis Assistance
Other Service	Community Transition Services
Other Service	Environmental Modifications
Other Service	Family and Caregiver Training
Other Service	Music Therapy
Other Service	Occupational Therapy
Other Service	Personal Emergency Response System
Other Service	Physical Therapy
Other Service	Psychological Therapy
Other Service	Recreational Therapy
Other Service	Specialized Medical Equipment and Supplies
Other Service	Speech/Language Therapy

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult Day Services are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, and therapeutic activities, supervision, support services, and personal care. Meals and/or nutritious snacks are required. The meals cannot constitute the full daily nutritional regimen.

However, each meal must meet 1/3 of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting in one of three available levels of service; Basic, Enhanced or Intensive.

Individuals attend Adult Day Services on a planned basis.

Allowable Activities

BASIC ADULT DAY SERVICES (Level 1) includes:
• Monitor and/or supervise all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed.
• Comprehensive, therapeutic activities.
• Health assessment and intermittent monitoring of health status.
• Monitor medication or medication administration.
• Appropriate structure and supervision for those with mild cognitive impairment.
• Minimum staff ratio: One staff for each eight individuals.

ENHANCED ADULT DAY SERVICES (Level 2) includes:
Level 1 service requirements must be met. Additional services include:
• Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care.
• Health assessment with regular monitoring or intervention with health status.
• Dispense or supervise the dispensing of medication to individuals.
• Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers.
• Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments.
• Minimum staff ratio: One staff for each six individuals.

INTENSIVE ADULT DAY SERVICES (Level 3) includes:
Level 1 and Level 2 service requirements must be met. Additional services include:
• Hands-on assistance or supervision with all ADLs and personal care.
• One or more direct health intervention(s) required.
• Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available.
• Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care.
• Therapeutic interventions for those with moderate to severe cognitive impairments.
• Minimum staff ratio: One staff for each four individuals.

Service Standards
• Adult Day Services must follow a written Plan of Care addressing specific needs determined by the individual's assessment.

Documentation Standards
• Services outlined in the POC/CCB.
• Evidence that level of service provided is required by the individual.
• Attendance record documenting the date of service and the number of units of service delivered that day.
• Completed Adult Day Service Level of Service Evaluation form.
Case manager should give the completed Adult Day Service Level of Service Evaluation to the provider.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult Day Services are allowed for a minimum of 3 hours to a maximum of 12 hours per day.

ACTIVITIES NOT ALLOWED
• Any activity that is not described in allowable activities is not included in this service.

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Adult Day Service Facilities

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:
Agency
Provider Type:
DDRS Approved Adult Day Service Facilities
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS-approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-2 Qualification for ADS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training. Must comply with BDDS Adult Day Service Standards and Guidelines

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service
Service:
Day Habilitation
Alternate Service Title (if any):
Day Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Day Services means services outside of an individual's home that support, in general, learning and assistance in any of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living, including development of employment skills. These activities are directly related to the Individualized Support Plan (ISP). Each individual receiving Day Services works toward acquiring the skills to become an active member of the community. The continuum of services within Day Services provides opportunities in facility based and the community based services to become more independent and more integrated within community activities. Day Services can be delivered to an individual one-on-one or in a group setting and in the community, work setting, or facility.

Allowable Activities
• Direct supervision, monitoring, training, education, demonstration or support to assist with
• An individual's personal needs (feeding, toileting, and so forth)
• Transportation (excluding transportation that is covered under the Medicaid State Plan)
• Acquisition, improvement and retention of daily living skills
• Training and learning in the areas of employment skills, educational opportunities, hobbies and leisure activities
• Development of self-advocacy skills, acquiring skills that enable an individual to exercise control and responsibility over services and supports received or needed
• Activities that are directly related to the outcomes outlined in the Individualized Support Plan (ISP)
• Prevocational related activities that are compensated and paid to the individual at less than 50 percent of the minimum wage

Service Standards
• Day Services must be reflected in the ISP.
• Services must address needs identified in the person centered planning process and be outlined in the ISP.

Documentation Standards
Day Services documentation must include:
• Approved provider credentials
• Documentation for each day of service rendered. The specific data elements required for each day of service include the following:
Type and unit of service
Name of individual served
RID Number of the individual
Date of service (including the year)
Notation of the primary location at which the service was rendered
A description of an issue or circumstance concerning the individual made by direct care staff. The entry should include complete time and date of the entry (include a.m. or p.m.) and a signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are acceptable if the provider has a log on file that shows the staff member's electronic signature, their actual signature and their printed name. A minimum of one entry per shift is required.
• Documentation in compliance with 460 IAC 6, Supported Living Services and Supports requirements.

Clinical or progress documentation is also required and must include:
• The provider must complete a monthly summary of the individual's progress towards outcomes, using the approved form. This is a narrative summary, about one page in length, that describes the individual's day service activities, and must address outcomes in the individual's ISP, as well as a high level summary of issues affecting the health, safety and welfare of the individual requiring intervention by a healthcare professional, case manager, behavior support services provider or BDDS staff member.
• This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ACTIVITIES NOT ALLOWED
• Services furnished to a minor by the parent(s), step-parent(s), or legal guardian
• Services furnished to an individual by the person's spouse
• Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-124
• Services that are available under the Medicaid State Plan

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDRS Approved Individuals
Agency	DDRS Approved Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Services

Provider Category:
Individual
Provider Type:
DDRS Approved Individuals
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-5-14 Health Care Coordination Services provider,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-5-29 Supported Employment provider qualifications,
460 IAC 6-14-4 Staff Training

Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:

Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Services

Provider Category:
Agency
Provider Type:
DDRS Approved Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-5-29 Supported Employment Services provider qualifications,
460 IAC 6-5-20 Prevocational Services provider qualifications, 460 IAC 6-14-4 Staff Training
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Live-in Caregiver (42 CFR §441.303(f)(8))
Alternate Service Title (if any):
Rent and Food for Unrelated Live-In Caregiver

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*
Rent and Food for an Unrelated, Live-in Caregiver Supports means the additional cost an individual incurs for the room and board of an unrelated, live-in caregiver as provided for the individual's Residential Budget.

Allowable Activities
• The individual receiving these services lives in his or her own home
• For payment to not be considered income for the individual receiving services, payment for the portion of the costs of rent and food attributable to an unrelated, live-in caregiver must be made directly to the live-in caregiver
• Room and board for the unrelated live-in caregiver (who is not receiving any other financial reimbursement for the provision of this service)
• Room: shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services
• Board: three meals a day or other full nutritional regimen
• Unrelated: unrelated by blood or marriage to any degree
• Caregiver: an individual providing a covered service as defined by BDDS service definitions or in a Medicaid HCBS waiver, to meet the physical, social or emotional needs of the individual receiving services

Service Standards
• Rent and Food for an Unrelated Live-in Caregiver should be reflected in the Individualized Support Plan of the individual
• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
• Services must complement other services the individual receives and enhance increasing independence for the individual
• The person centered planning team will decide and assure that the individual who will serve as a live-in caregiver has the experience, skills, training and knowledge appropriate to the individual and the type of support needed

Documentation Standards
• Rent and Food for Unrelated Live-in Caregiver documentation must include:
• Identified in the Individualized Support Plan
• Documentation of how amount of Rent and Food was determined
• Receipt that funds were paid to the individual
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ACTIVITIES NOT ALLOWED
• When the individual lives in the home of the caregiver or in a residence owned or leased by the provider of other services, including Medicaid waiver services
• When the live-in caregiver is related by blood or marriage (to any degree) to the individual

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDRS Approved Residential Habilitation and Support Provider
Agency	DDRS Approved Residential Habilitation and Support provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Rent and Food for Unrelated Live-In Caregiver

Provider Category:
Individual

Provider Type:
DDRS Approved Residential Habilitation and Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-5-23 Rent/Food for Unrelated Live-In Caregiver Supports provider qualifications,
460 IAC 6-5-24 Qualifications for RHS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Rent and Food for Unrelated Live-In Caregiver

Provider Category:
Agency

Provider Type:
DDRS Approved Residential Habilitation and Support provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-5-23 Rent/Food for Unrelated Live-In Caregiver Supports provider qualifications,
460 IAC 6-5-24 Qualification for RHS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):
Residential Habilitation and Support

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Residential Habilitation and Support service providers are responsible for the health, safety and welfare of the individual, and assist in the acquisition, improvement, and retention of skills necessary to support individuals to live successfully in their own homes.

Allowable Activities
• Direct supervision, monitoring and training to implement the Individualized Support Plan (ISP) outcomes for the individual through the following:
• Assistance with personal care, meals, shopping, errands, chore and leisure activities and transportation (excluding transportation that is covered under the Medicaid State Plan)
• Coordination and facilitation of medical and non-medical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, utilization of available supports in a cost effective manner and maintenance of each individual's health record
• Assurance that direct service staff are aware and active individuals in the development and implementation of ISP and Behavior Support Plans

Service Standards
• Residential habilitation supports must be reflected in the Individualized Support Plan.
• Provider owned or leased facilities where residential habilitation and support services are furnished must be compliant with the Americans with Disabilities Act.
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Documentation Standards
Residential Habilitation and Support services documentation must include:
• Approved provider credentials
• Documentation for each day of service rendered. The specific data elements required for each day of service include the following:
Type and unit of service
Name of individual served
RID Number of the individual

Date of service (including the year)
Notation of the primary location at which the service was rendered
A description of an issue or circumstance concerning the individual made by direct care staff. The entry should include complete time and date of the entry (include a.m. or p.m.) and a signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are acceptable if the provider has a log on file that shows the staff member's electronic signature, their actual signature and their printed name. A minimum of one entry per shift is required.
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Clinical/Progress Documentation is also required and must include:
• The provider must complete a monthly summary of the individual's progress toward outcomes, using the approved form. This is a narrative summary, about one page in length, that describes the individual's residential habilitation supports activities, and must address outcomes in the individual's ISP, as well as a high level summary of issues affecting the health, safety and welfare of the individual requiring intervention by a healthcare professional, case manager, behavior support services provider or BDDS staff member.
• This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ACTIVITIES NOT ALLOWED
• Services furnished to a minor by the parent(s), step-parent(s), or legal guardian
• Services furnished to an individual by the person's spouse
• Services to individuals in Adult Foster Care or Children's Foster Care
• Services that are available under the Medicaid State Plan
• Services furnished to an adult individual by a parent, step-parent or guardian, that exceed 40 hours per week

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved RHS Agencies
Individual	DDRS Approved RHS Individuals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation and Support

Provider Category:
Agency
Provider Type:
DDRS Approved RHS Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-5-24 Qualification for RHS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
RN and LPN staff must meet IC 25-23

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation and Support

Provider Category:
Individual

Provider Type:
DDRS Approved RHS Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-5-24 Qualification for RHS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respite Care services means services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing care.

Respite Care can be provided in the individual's home or place of residence, in the caregiver's home, in a non-private residential setting (such as a respite home), or in a camp setting.

Allowable Activities:
Assistance with toileting and feeding
• Assistance with daily living skills, including assistance with accessing the community and community activities
• Assistance with grooming and personal hygiene
• Meal preparation, serving and cleanup
• Administration of medications
• Supervision

Service Standards
• The level of care and type of respite care will not exceed the requirements of the plan of care. Therefore, skilled nursing services will only be provided when the needs of the client warrant skilled care. Other respite care such as attendant care will be provided by the appropriate provider when nursing services are not required.
• If an individual's needs can be met with an LPN, but an RN provides the service, the service may only be billed at the LPN rate, per Indiana Health Coverage Programs (IHCP) provider bulletin BT200371.
• Respite care must be reflected in the Individualized Support Plan

Documentation Standards
• Documentation must include the following elements: the reason for the respite, the location where the service was rendered and the type of respite rendered. For example, respite Home Health Agency (HHA).
• Data Record of staff to client service documenting the complete date and time in and time out, and the number of units of service delivered that day.
• Each staff member providing direct care or supervision of care to the client makes at least one entry on each day of service describing an issue or circumstance concerning the client.
• Documentation should include date and time, and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, the title of the individual must also be included. For example, if a nurse is required to perform the service then the RN title would be included with the name.
• Any significant issues involving the client requiring intervention by a health care professional, or case manager that involved the client also needs to be documented.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED
• Respite care shall not be used as day/child care to allow the persons normally providing care to go to work.
• Respite care shall not be used as day/child care to allow the persons normally providing care to attend school.
• Respite care shall not be used to provide service to a member while member is attending school.

• Respite care may not be used to replace skilled nursing services that should be provided under the Medicaid State Plan
• Services provided by the parent of a minor child or the individual's spouse
• Respite care must not duplicate any other service being provided under the individual's POC/ISP.
• Reimbursement for room and board
• Services provided to an individual living in a licensed facility based setting
• The cost of registration fees or the cost of recreational activities (e.g. camp, etc.)
• When the service of Adult Foster Care or Children's Foster Care is being furnished to the individual

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDRS Approved Respite Providers - Individual Respite
Agency	DDRS Approved Licensed Home Health Agencies
Agency	DDRS Approved Respite Agencies
Individual	DDRS Approved Respite Providers - Individual Skilled Nursing

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Individual
Provider Type:
DDRS Approved Respite Providers - Individual Respite
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
DDRS Approved Licensed Home Health Agencies
Provider Qualifications
License *(specify):*
Home Health Agency IC 16-27-1, RN and LPN IC 25-23-1
Certificate *(specify):*
Home Health Aide Registered IC 16-27-1.5
Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
DDRS Approved Respite Agencies
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Individual

Provider Type:
DDRS Approved Respite Providers - Individual Skilled Nursing

Provider Qualifications

License *(specify):*
IC 25-23 Licensed and Registered Nurse

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-4 Staff Training

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Adult Foster Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Adult Foster Care Services means a living arrangement in which an individual lives in the private home of a principal caregiver who is unrelated to the individual.

Necessary support services are provided by the principal caregiver (a foster parent) as part of Adult Foster Care Services. Only agencies may be foster care providers, with the foster care settings being approved, supervised, trained, and paid by the approved agency provider. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Adult Foster Care Services, since these services are integral to and inherent in the provision of adult foster care services.

Rate Levels
There are three levels of rates. The Individualized Support Team (IST) determines what level of supports are required for the individual, based on what services an individual would utilize if foster care services were not available. A Service Planner must be completed showing the services and amounts of services required in another setting. If there are changes in the individual's condition that may call for a change in the level of service, the IST will re-determine what level of supports the individual requires, with ultimate approval given according to who can approve a specific level of service.
• Level 1 – Approved by Service Coordinator
• Level 2 – Approved by District Manager
• Level 3 – Approved by Central Office
Issues to consider in determining which tier of services the individual receives include the amount of time the foster family will need to spend in:
1) health and safety management;
2) challenges and experiences aimed at increasing a person's ability to live a lifestyle that is compatible with the person's interest and abilities;
3) modification or improvement of functional skills;
4) guidance and direction for social/emotional support; and
5) facilitation of both the physical and social integration of a person into typical family routines and rhythms.

Allowable Activities
• Personal care and services
• Homemaker or chore services
• Attendant care and companion care services
• Medication oversight
• Respite for the foster parent (funding for this respite is included in the per diem paid to the service provider, the actual service of Respite Care may not be billed in addition to the per diem)
• Other appropriate supports as described in the Individualized Support Plan

Service Standards
• Adult Foster Care Services must be reflected in the Individualized Support Plan
• Services must address the needs (for example, developmental needs, vocational needs, and so forth) identified in the person centered planning process and be outlined in the Individualized Support Plan
• 10% of the total per diem amount is intended for use by the provider for respite care as needed. It is the provider's responsibility to approve any providers of respite chosen by the family or the individual
• The provider determines the total amount per month paid to the foster parent
• The agency's administrative/supervision fee comes from the remaining total amount and includes the following duties:
1) Publish written policies and procedures regarding foster parent support services;
2) Maintain financial and service records to document services provided to the individual;
3) Establish a criteria for the acceptance of the foster parent, screen potential foster parents for qualities of stability, maturity, and experiences so as to ensure the safety and well being of the individual, and obtain a criminal background and reference check;
4) Coordinate/provide adequate initial training and ongoing training, consultation and supervision to the foster parent;
5) Provide for the safety and well being of the individual by inspection of environment for compliance with DDRS policies and procedures, including, but not limited to, the provider and case management standards found in 460 IAC 6 Supported Living Services and Supports requirements; and
6) Reimburse foster parent.

Documentation Standards
• Adult Foster Care Services documentation must include the services outlined in the Individualized Support

Plan.

Documentation by Providers:
• Written policies and procedures, including for screening and accepting foster parents.
• Maintain financial and service records to document services provided to the individual.
• Document provision of training to foster parents according to agency policies/procedures.
• Reimbursement of foster parent.
• One entry per individual per week (same as families).

Documentation by Families:
• One dated entry per day detailing an issue concerning the individual
• The entry should detail any outcome-oriented activities, tying those into measurable progress toward the individual's outcome (as identified in the ISP)
• The entry should also include any significant issues concerning the individual, including:
  • Health and safety management
  • Developmental challenges and experiences aimed at increasing an individual's ability to live a lifestyle that is compatible with the individual's interest and abilities
  • Modification or improvement of functional skills
  • Guidance and direction for social/emotional support
  • Facilitation of both the physical and social integration of an individual into typical family routines and rhythms

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
For individuals receiving services under the Autism Waiver, an individual in LEVEL 1 may reside with a family and up to three other individuals (no more than four total), an individual in LEVEL 2 may not reside with more than one other individual. An individual in LEVEL 3 may not reside with any other individuals in the AFC program.

ACTIVITIES NOT ALLOWED
• Services provided in the home of a caregiver who is related by blood or marriage, in any degree, to the individual
• The service of Residential Habilitation and Supports is not available to individuals receiving the service of Adult Foster Care

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved AFC Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Foster Care

Provider Category:
Agency
Provider Type:
DDRS Approved AFC Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-3 Adult Foster Care qualifications,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-14-4 Staff Training

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Behavioral Support Services/Crisis Assistance

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Behavioral Support Services means training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

Allowable Activities
• Reimbursable activities of Behavioral Support Services include:
• Observation of the individual and environment for purposes of development of a plan and to determine baseline
• Development of a behavioral support plan and subsequent revisions
• Obtain consensus of the Individualized Support Team that the behavioral support plan is feasible for implementation.
• Training in assertiveness
• Training in stress reduction techniques
• Training in the acquisition of socially accepted behaviors

• Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan
• Consultation with team members
• Consultation with Health Service Providers in Psychology (HSPP)

Service Standards
• Behavioral Support Services must be reflected in the Individualized Support Plan
• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
• The behavior supports specialist will observe the individual in his or her own milieu and develop a specific plan to address identified issues.
• The behavior supports specialist must assure that Residential Habilitation and Supports direct service staff are aware of and are active individuals in the development and implementation of the Behavioral Support Plan.
• The behavior plan will meet the requirements stated in 460 IAC 6-18-2.
• The behavior supports provider will comply with all specific standards in 460 IAC 6-18.
• Any behavior supports techniques that limit the individual's human or civil rights must be approved by the Individualized Support Team (IST) and the provider's human rights committee. No aversive techniques may be used. Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with caution. The use of these medications must be approved by the Individualized Support Team (IST) and the appropriate human rights committee.
• The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary.
• The behavior specialist will provide a written report to pertinent parties at least quarterly. Pertinent parties includes the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other involved entities.

Documentation Standards
• Services outlined in the ISP.
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ACTIVITIES NOT ALLOWED
• Aversive techniques – Any techniques not approved by the individual's person centered planning team and the provider's human rights committee.
• In the event that a Level 1 clinician performs, Level 2 clinician activities, billing for Level 1 services is not allowed. In this situation, billing for level 2 services only is allowed.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved BSS/Crisis Assistance Agencies
Individual	DDRS Approved BSS/Crisis Assistance Individuals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services/Crisis Assistance

Provider Category:

Agency

Provider Type:
DDRS Approved BSS/Crisis Assistance Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-4 Behavioral Support Services Provider qualifications,
460 IAC 6-5-9 Crisis Assistance Provider qualifications,
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services/Crisis Assistance

Provider Category:
Individual
Provider Type:
DDRS Approved BSS/Crisis Assistance Individuals
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-4 Behavioral Support Services Provider Qualifications
460 IAC 6-5-9 Crisis Assistance Provider Qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Transition Services include reasonable, one-time set-up expenses for individuals who make the transition from an institution to their own home in the community and will not be reimbursable on any subsequent move.

Note: Own Home is defined as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the individual and/ or the individual's guardian or family, or a home that is owned and/ or operated by the agency providing supports.

Items purchased through Community Transition Services are the property of the individual receiving the service, and the individual takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition Services because those services are part of the per diem.

Allowable Activities
• Security deposits that are required to obtain a lease on an apartment or home.
• Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, window coverings, eating utensils, food preparation items, bed or bath linens
• Set-up fees or deposits for utility or service access including telephone, electricity, heating, and water
• Health and safety assurances including pest eradication, allergen control, or one time cleaning prior to occupancy
• When the individual is receiving residential habilitation and support services under the Autism Waiver, the Community Transition Supports service is included in the Cost Comparison Budget

Service Standards
• Community Transition services must be reflected in the Cost Comparison Budget (CCB) of the individual.
• Services must address needs identified in the CCB.

Documentation Standards
• Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community Transition Services are limited to one time set-up expenses, up to $1,000.

ACTIVITIES NOT ALLOWED
• Apartment or housing rental expenses
• Food
• Appliances
• Diversional or recreational items such as hobby supplies
• Television
• Cable TV access

• VCRs

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Residential Habilitation and Support Agencies
Individual	DDRS Approved Residential Habilitation and Support Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Agency
Provider Type:
DDRS Approved Residential Habilitation and Support Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved Agencies
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-34 Community Transition Staff Qualifications,
460 IAC 6-14-4 Staff Training
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:
DDRS Approved Residential Habilitation and Support Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-34 Community Transitions Staff Qualifications,
460 IAC 6-14-4 Staff Training
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Environmental Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
ENVIRONMENTAL MODIFICATIONS
Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.
Waiver Services must approve all environmental modifications prior to service being rendered.

Allowable Activities
• Installation of ramps and grab bars
• Widening doorways
• Modifying existing bathroom facilities
• Installation of specialized electric and plumbing systems necessary to accommodate the medical equipment

and supplies which are necessary for the welfare of the individual
• Maintenance and repair of the items and modifications installed during the initial request
• Anti-scald devices

Service Standards
• Equipment and supplies must be for the direct medical or remedial benefit of the individual
• All items shall meet applicable standards of manufacture, design and installation to ensure that environmental modifications meet the needs of the individual and abide by established, federal, state, local and FSSA standards, as well as ADA requirements, approved environmental modifications will reimburse for necessary:
• Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications
• Independent inspections during the modification process and at completion of the modifications, prior to authorization for reimbursement, based on the complexities of the requested modifications.
• Equipment and supplies shall be reflected in the Individualized Support Plan
• Equipment and supplies must address needs identified in the person centered planning process

Documentation Standards
• Identified direct medical benefit for the individual
• Documented "Prior Authorization Denial" from Medicaid, if applicable
• Receipts for purchases
• Identified need in Individualized Support Plan
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Reimbursement for Environmental Modification Supports has a lifetime cap of $15,000.

Service and repair up to $500 per year, outside this cap, is permitted for maintenance and repair of prior modifications that were funded by a waiver service.

(If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.)

ACTIVITIES NOT ALLOWED
• Adaptations to the home which are of general utility
• Adaptations which are not of direct medical or remedial benefit to the individual (such as carpeting, roof repair, central air conditioning)
• Adaptations which add to the total square footage of the home
• Adaptations that are not included in the comprehensive plan of care
• Adaptations that have not been approved on a Request for Approval to Authorize Services
• Adaptations to service provider owned housing. Home accessibility modifications as a service under the waiver may not be furnished to individuals who receive residential habilitation and support services except when such services are furnished in the participant's own home. Compensation for the costs of life safety code modifications and other accessibility modifications may not be made with participant waiver funds to housing owned by providers.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Agencies

Individual	**Qualified contractors, architects, licensed contractors, builders, individuals, home inspectors, plumbers, licensed PT, OT, ST - Individual**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency
Provider Type:
DDRS Approved Agencies
Provider Qualifications
License *(specify):*
Home Health Agencies IC 16-27-1
Service provided by Licensed OT (IC 25-23.5) ,PT (IC 25-27-1),ST (IC 25-35.6)
Certificate *(specify):*
Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-11 Environmental Modification Qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual
Provider Type:
Qualified contractors, architects, licensed contractors, builders, individuals, home inspectors, plumbers, licensed PT, OT, ST - Individual
Provider Qualifications
License *(specify):*
Home Inspector IC 25-20.2
Plumber IC 25-28.5
Physical Therapist IC 25-27-1
Occupational Therapist IC 25-23.5
Speech/Language Therapist IC 25-35.6
Certificate *(specify):*
Architect IC 25-4-1
Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,

460 IAC 6-11 Financial Status of Provider,
460 IAC 6-5-11 Environmental Modification Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Family and Caregiver Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Family and Caregiver Training Services provides training and education to:
(1) instruct a parent, other family member, or primary caregiver about the treatment regimens and use of equipment specified in the Individualized Support Plan; and
(2) improve the ability of the parent, family member or primary caregiver to provide the care to or for the individual.

Allowable Activities
• Treatment regimens and use of equipment
• Stress management
• Parenting
• Family dynamics
• Community integration
• Behavioral intervention strategies
• Mental health
• Caring for medically fragile individuals

Service Standards
• Family and Caregiver Training Services must be included in the Individualized Support Plan
• The Individualized Support Plan shall be based on the person centered planning process with that individual.

Documentation Standards
• Services outlined in the Individualized Support Plan
• Receipt of payment for activity
• Proof of participation in activity if payment is made directly to individual/family.
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Funds for this service are limited to no more than $2,000/year

ACTIVITIES NOT ALLOWED
• Training/instruction not pertinent to the caregiver's ability to give care to the individual
• Training provided to caregivers who receive reimbursement for training costs within their Medicaid or state line item reimbursement rates
• Meals, accommodations, etc., while attending the training

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies Approved by DDRS to Provide Residential Habilitation and Supports
Individual	Individuals Approved by DDRS to Provide Residential Habilitation and Supports

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family and Caregiver Training

Provider Category:
Agency
Provider Type:
Agencies Approved by DDRS to Provide Residential Habilitation and Supports
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-13 and 6-23-1 Family and Caregiver Training Qualifications,
460 IAC 6-14-4 Staff Training
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family and Caregiver Training

Provider Category:
Individual

Provider Type:
Individuals Approved by DDRS to Provide Residential Habilitation and Supports

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-13 and 6-23-1 Family and Caregiver Training Qualifications,
460 IAC 6-14-4 Staff Training

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Music Therapy

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Music Therapy Services means services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition of nonmusical skills and behaviors.

Allowable Activities
• Therapy to improve
Self-image and body awareness

Fine and gross motor skills
Auditory perception
• Therapy to increase
Communication skills
Ability to use energy purposefully
Interaction with peers and others
Attending behavior
Independence and self-direction
• Therapy to reduce maladaptive (stereotypic, compulsive, self-abusive, assaultive, disruptive, perseverative, impulsive) behaviors.
• Therapy to enhance emotional expression and adjustment.
• Therapy to stimulate creativity and imagination. The music therapist may provide services directly or may demonstrate techniques to other service personnel or family members

Service Standards
• Music Therapy Services should be reflected in the Individualized Support Plan of the individual
• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan. Services must complement other services the individual receives and enhance increasing health and safety for the individual

Documentation Standards
• Documentation of appropriate assessment by a qualified therapist
• Services outlined in Individualized Support Plan
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements
• Appropriate credentials for service provider
• Attendance record, therapist logs and/or chart detailing service provided, date and times
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ACTIVITIES NOT ALLOWED
• When services are reimbursable through the Medicaid State Plan.
• Specialized equipment needed for the provision of Music Therapy Services should be purchased under "Specialized Medical Equipment and Supplies Supports"

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Approved Music Therapist - Individual
Agency	Agency that Employs Approved Music Therapist - Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Music Therapy

Provider Category:
Individual

Provider Type:
Approved Music Therapist - Individual
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified Music Therapist By a Certification Board for Music Therapist, that is Accredited by a National Commission for Certifying Agencies
Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-15 Music Therapy Provider Qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Music Therapy

Provider Category:
Agency
Provider Type:
Agency that Employs Approved Music Therapist - Agency
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified Music Therapist by a Certification Board for Music Therapist, that is Accredited by a National Commission for Certifying Agencies
Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-15 Music Therapy Provider qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Occupational Therapy

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Occupational Therapy Services means services provided under 460 IAC 6-5-17 by a licensed/certified occupational therapist.

Allowable Activities

• Evaluation and training services in the areas of gross and fine motor function, self-care and sensory and perceptual motor function.
• Screening
• Assessments
• Planning and reporting
• Direct therapeutic intervention
• Design, fabrication, training and assistance with adaptive aids and devices
• Consultation or demonstration of techniques with other service providers and family members
• Participating on the interdisciplinary team, when appropriate, for the development of the plan

Service Standards

• Individual Occupational Therapy Services must be reflected in the Individualized Support Plan.
• The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards

• Documentation by appropriate assessment by a qualified therapist
• Services outlined in the Individualized Support Plan
• Appropriate credentials for service provider
• Attendance record, therapist logs and/or chart detailing service provided, date and times
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED

• Activities not delivered one-on-one with the individual
• Activities delivered in a nursing facility
• Activities that are available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed/Certified Occupational Therapist
Agency	DDRS Approved Agency Providing Occupational Therapy
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:
Individual
Provider Type:
Licensed/Certified Occupational Therapist
Provider Qualifications
License *(specify):*
IC 25-23.5 (Licensure and certification requirments)
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-17 Occupational Therapy qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
DDRS Approved Agency Providing Occupational Therapy
Provider Qualifications
License *(specify):*
Occupational Therapist IC 25-23.5
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved

460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-17 Occupational Therapy provider qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:
Agency

Provider Type:
Home Health Agencies

Provider Qualifications

License *(specify):*
IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-17 Occupational Therapy provider qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Personal Emergency Response System

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

○ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

Allowable Activities
• PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision.
• Device Installation service
• Ongoing monthly maintenance of device

Service Standards
• Must be included in the individual's plan of care.

Documentation Standards
• Identified need in the POC/CCB
• Documentation of expense for installation
• Documentation of monthly rental fee
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ACTIVITIES NOT ALLOWED
• Reimbursement is not available for Personal Emergency Response System Supports when the individual requires constant supervision to maintain health and safety.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency
Provider Type:
DDRS Approved Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Provider,
460 IAC 6-5-18 Personal Emergency Response System Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Physical Therapy

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Physical Therapy Services means services provided under this article by a licensed physical therapist Allowable Activities

Allowed Activities
• Screening and assessment
• Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone, activities of daily living
• Planning and reporting
• Direct therapeutic intervention
• Training and assistance with adaptive aids and devices
• Consultation or demonstration of techniques with other service providers and family members
• Participating on the interdisciplinary team, when appropriate, for the development of the service plan

Service Standards
• Individual Physical Therapy Services must be reflected in the Individualized Support Plan.
• The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards
• Physical Therapy Services documentation must include:

• Documentation by appropriate assessment
• Services outlined in the Individualized Support Plan
• Appropriate credentials for service provider
• Attendance record, therapist logs, and chart detailing service provided, date, and times.
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ACTIVITIES NOT ALLOWED
• Activities not delivered one-on-one with the individual
• Activities delivered in a nursing facility
• Activities available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the waiver for this service)

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies
Individual	Licensed Physical Therapist
Agency	DDRS Approved Agency Providing Physical Therapy

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
Home Health Agencies
Provider Qualifications
License *(specify):*
IC 16-27-1
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-19 Physical Therapy Provider qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:
Individual
Provider Type:
Licensed Physical Therapist
Provider Qualifications
License *(specify):*
IC 25-27-1
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-19 Physical Therapy Qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
DDRS Approved Agency Providing Physical Therapy
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-19 Physical Therapy Provider qualifications
Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Psychological Therapy

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Therapy Services means services provided under 460 IAC 6-3-56 by a licensed psychologist with an endorsement as a health service provider in psychology, a licensed marriage and family therapist, a licensed clinical social worker, or a licensed mental health counselor.

Allowable Activities
• Individual counseling
• Biofeedback
• Individual-centered therapy
• Cognitive behavioral therapy
• Psychiatric services
• Crisis counseling
• Family counseling
• Group counseling
• Substance abuse counseling and intervention

Service Standards
• Therapy Services should be reflected in the Individualized Support Plan of the individual.
• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
• Services must complement other services the individual receives and enhance increasing independence for the individual

Documentation Standards
• Documentation by appropriate assessment
• Services outlined in the Individualized Support Plan
• Appropriate credentials for service provider
• Attendance record, therapist logs and/or chart detailing service provided, date and times
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ACTIVITIES NOT ALLOWED
• Reimbursement is not available for Therapy Services when services are reimbursable through the Medicaid

State Plan. Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical Social Worker
Individual	Licensed Psychologists
Individual	Mental Health Counselor
Agency	DDRS Approved Qualified Agencies
Individual	Marriage/Family Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Therapy

Provider Category:
Individual
Provider Type:
Clinical Social Worker
Provider Qualifications
License *(specify):*
IC 25-23.6
Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Psychological Therapy

Provider Category:
Individual
Provider Type:
Licensed Psychologists
Provider Qualifications
License *(specify):*
IC 25-33-1-5.1
Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Therapy

Provider Category:
Individual
Provider Type:
Mental Health Counselor
Provider Qualifications
License *(specify):*
IC 25-23.6
Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Therapy

Provider Category:
Agency
Provider Type:
DDRS Approved Qualified Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications,
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Therapy

Provider Category:
Individual
Provider Type:
Marriage/Family Therapist
Provider Qualifications
License *(specify):*
IC 25-23.6
Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications,
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Recreational Therapy

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Recreational Therapy Services means services provided under this article and consisting of a medically approved recreational program to restore, remediate, or rehabilitate an individual in order to:
(1) improve the individual's functioning and independence; and
(2) reduce or eliminate the effects of an individual's disability.

Allowed Activities
• Planning, organizing and directing, Adapted sports, Dramatics, Arts and crafts, Social activities, other recreation services designed to restore, remediate or rehabilitate.

Service Standards
• Recreational Therapy Services should be reflected in the Individualized Support Plan of the individual.
• Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan.
• Services must complement other services the individual receives and enhance increasing independence for the individual

Documentation Standards
• Documentation by appropriate assessment
• Services outlined in Individualized Support Plan
• Appropriate credentials for service provider
• Attendance record, therapist logs, and/or chart detailing service provided, date, and times
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT ALLOWED
• Payment for the actual activities being planned, organized and directed, when the services are reimbursable through the Medicaid State Plan.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Approved Recreational Therapist
Agency	Agency That Employs Approved Recreational Therapists

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Recreational Therapy

Provider Category:
Individual
Provider Type:
Approved Recreational Therapist
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-22 Recreational Therapy Provider Qualifications
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Recreational Therapy

Provider Category:
Agency
Provider Type:
Agency That Employs Approved Recreational Therapists
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,

460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-22 Recreational Therapy provider qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live and without which the individual would require institutionalization.
Waiver Services must approve all specialized medical equipment and supplies prior to service being rendered.

Allowable Activities
• Items necessary for life support
• Adaptive equipment and supplies
• Ancillary supplies and equipment needed for the proper functioning of specialized medical equipment and supplies
• Durable medical equipment not available under Medicaid State Plan
• Non-durable medical equipment not available under Medicaid State Plan
• Vehicle Modifications
• Communications devices
• Interpreter services

Service Standards
• Equipment and supplies must be of direct medical or remedial benefit to the individual
• All items shall meet applicable standards of manufacture, design and installation
• Any individual item costing over $500 requires an evaluation by a qualified professional such as a physician, nurse, Occupational Therapist, Physical Therapist, Speech and Language Therapist or Rehabilitation Engineer
• Annual maintenance service is available and is limited to $500 per year. If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need

Documentation Standards

• Identified need in POC/CCB.
• Identified direct medical benefit for the individual.
• Documentation of the request for IHCP prior approval (denied PA).
• Documentation of the reason of denial of IHCP prior authorization.
• Receipts for purchases.
• Signed and approved Request for Approval to Authorize Services (State Form 45750)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service and repair up to $500 per year is permitted for maintenance and repair of previously obtained specialized medical equipment that was funded by a waiver service. If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need.

A lifetime cap of $15,000.00 is available for vehicle modifications. In addition to the $15,000.00 lifetime cap, $500.00 will be allowable annually for repair, replacement, or an adjustment to an existing modification that has been provided through the HCBS waiver. If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.

ACTIVITIES NOT ALLOWED
• Equipment and services that are available under the Medicaid State Plan
• Equipment and services that are not of direct medical or remedial benefit to the individual
• Equipment and services that are not included in the comprehensive plan of care
• Equipment and services that have not been approved on a Request for Approval to Authorize services (RFA)
• Equipment and services that are not reflected in the Individualized Support Plan
• Equipment and services that do not address needs identified in the person centered planning process

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed/Certified Occupational Therapist
Agency	DDRS Approved Medical Supply Companies, Pharmacies, Electronics/Computer Companies, Vehicle Modification Provider , Electronics Vendors
Agency	Home Health Agencies
Individual	Licensed Speech/Language Therapist
Individual	Licensed Physical Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Individual
Provider Type:
Licensed/Certified Occupational Therapist
Provider Qualifications
License *(specify):*

IC 25-23.5 Licensure and Certification requirements
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
DDRS Approved Medical Supply Companies, Pharmacies, Electronics/Computer Companies, Vehicle Modification Provider , Electronics Vendors
Provider Qualifications

License *(specify):*

Certificate *(specify):*
IC 25-26-13-18 Pharmacy
Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Provider,
460 IAC 6-5-27 Specialized Medical Equipment & Supplies Provider Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Home Health Agencies

Provider Qualifications

License *(specify):*
IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Individual

Provider Type:
Licensed Speech/Language Therapist

Provider Qualifications

License *(specify):*
IC 25-35.6

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Finanical Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Individual

Provider Type:

Licensed Physical Therapist

Provider Qualifications

License *(specify):*
IC 25-27-1

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Speech/Language Therapy

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Speech-Language Therapy Services means services provided by a licensed speech pathologist under 460 IAC 6 Supported Living Services and Supports requirements.

Allowable Activities
• Screening
• Assessment
• Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids.
• Evaluation and training services to improve the ability to use verbal or non-verbal communication.
• Language stimulation and correction of defects in voice, articulation, rate and rhythm.
• Design, fabrication, training and assistance with adaptive aids and devices.
• Consultation demonstration of techniques with other service providers and family members.
• Participating on the interdisciplinary team, when appropriate, for the development of the plan.

Service Standards
• Individual Speech-Language Therapy Services must be reflected in the Individualized Support Plan.

• To be eligible for this service, the individual must have been examined by a certified audiologist and/or a certified speech therapist who has recommended a formal speech/audiological program.
• The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards
• Documentation of an appropriate assessment
• Services outlined in the Individualized Support Plan
• BDDS approved provider
• Appropriate credentials for service provider
• Attendance record, therapist logs and/or chart detailing service provided, date and times.
• Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Activities Not Allowed
• Reimbursement for time spent in planning, reporting and write-up
• Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service). Therapies provided through this service will not duplicate therapies provided under any other service.
• Activities delivered in a nursing facility.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Speech/Language Therapist
Agency	DDRS Approved Agency providing Speech/Language Therapy
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech/Language Therapy

Provider Category:
Individual
Provider Type:
Licensed Speech/Language Therapist
Provider Qualifications

License *(specify):*
IC 25-35.6
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,

460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-28 Speech/Language Therapy Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech/Language Therapy

Provider Category:
Agency

Provider Type:
DDRS Approved Agency providing Speech/Language Therapy

Provider Qualifications

License *(specify):*
IC 25-35.6 licensed Speech/Language Therapist

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-28 Speech-Language Therapy provider qualifications,

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech/Language Therapy

Provider Category:
Agency

Provider Type:
Home Health Agencies

Provider Qualifications

License *(specify):*
IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,

460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-28 Speech-Language Therapy Provider Qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-certification, BQIS and/or vendor as described in H-1-c.

Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies

  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☑ **As an administrative activity.** *Complete item C-1-c.*

- ○ **None of the above apply** (i.e., case management is furnished as a waiver service)

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

FSSA/DDRS has a contract with Indiana Professional Management Group (IPMG) to conduct case management functions for waiver participants as a Medicaid administrative activity.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a) All waiver providers who have direct contact with waiver participants (including every employee, officer, or agent involved in the management, administration or provision of services under the Autism Waiver) must have criminal history checks.

b) As described within Appendix C-2-f, documented proof of the limited criminal history investigation is required and must be obtained from the Indiana central repository by the prospective provider agency before submitting the prospective provider's application for approval to provide services to the Division of Disability and Rehabilitative Services' (DDRS) Bureau of Developmental Disabilities Services (BDDS). The documented

proof must be on file at the time of original provider approval for all current employees.

Criminal history documentation requirements for providers are specified under 460 IAC 6-10-5 "General Administrative Requirements for Providers". The scope of the limited criminal history check is within the state and shall verify that the employee, officer, or agent has not been convicted of the following under Indiana Code Title 35. Criminal Law and Procedure or Title 31. Family Law and Juvenile Law:
• A sex crime (IC 35-42-4)
• Exploitation of an endangered adult (IC 35-46-1-12)
• Failure to report battery, neglect, or exploitation of an endangered adult (IC 35-46-1-13) or abuse or neglect of a child (IC 31-33-22-1)
• Theft (IC 35-43-4), if the person's conviction for theft occurred less than ten (10) years before the person's employment application date, except as provided in IC 16-27-2-5(a)(5)
• Murder (IC 35-42-1-1)
• Voluntary manslaughter (IC 35-42-1-3)
• Involuntary manslaughter (IC 35-42-1-4)
• Felony battery
• A felony offense relating to a controlled substance

The provider shall also obtain a criminal history check from each county in which an employee, officer or agent involved in the management, administration or provision of services has resided within the three (3) years before the criminal history check is requested from the county.

c) The BDDS reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of documented proof of the limited criminal history for each employee listed on the provider's organizational chart, the application shall not be approved.

Provider surveys conducted by the Bureau of Quality Improvement Services (BQIS) include the review for documented proof of the limited criminal history (for each employee, officer or agent of the provider agency) to verify that this practice continues with new hires. In the absence of such proof, a Corrective Action Plan shall be required from the provider as described within Appendix H-1-c. The BQIS surveys each provider at least every three (3) years.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) The Certified Nursing Assistant Abuse Registry is maintained by the Indiana State Department of Health and is available online at http://www.in.gov/isdh/regsvcs/ltc/cnafind/cnafind.htm.

b) Per 460 IAC 6-10-5(d), "Documentation of Criminal Histories", the state Bureau of Developmental Disabilities Services (BDDS) requires Certified Nursing Assistant Abuse Registry screenings for each direct care staff member employed by a provider of waiver services. Each provider or prospective provider is responsible for conducting the screening against the registry.

The Certified Nursing Assistant Abuse Registry documentation requirements for providers are specified under 460 IAC 6-10, "General Administrative Requirements for Providers".

c) The BDDS reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of the report from the state nurse aid registry for each direct care staff employed by the provider, the application shall not be approved.

The Bureau of Quality Improvement Services (BQIS) includes the requirement of reviewing for documented

proof of the report from the state nurse aid registry for each direct care staff employed by the provider within provider surveys to verify that this practice continues with new hires. The BQIS surveys each provider at least every three (3) years.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed

to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

• Waiver services may not be furnished to the participant by the parent(s), step-parent(s) or legal guardian when the participant is a minor child of the parent(s), step-parent(s) or legal guardian

• Waiver services may not be furnished to a participant by the participant's spouse

• Waiver services may not be furnished by any relative or legal guardian of the participant within an Adult Foster Care or Children's Foster Care setting

Payment may be made to relatives or legal guardians (including parents and/or step-parents of an adult child), for the following services as specified by the Individualized Support Plan and furnished to an adult participant served under the Autism Waiver whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3:
• Day Services
• Residential Habilitation and Support Services furnished to an adult participant by a parent, step-parent and/or legal guardian of the adult participant may not exceed a combined total of forty (40) hours per week
• Applied Behavioral Analysis
• Behavioral Support Services/Crisis Assistance
• Community Transition Services
• Environmental Modifications
• Music Therapy
• Occupational Therapy
• Physical Therapy
• Psychological Therapy
• Recreational Therapy
• Specialized Medical Equipment and Supplies
• Speech/Language Therapy

Payment for Respite Care may be made to relatives or legal guardians, excluding parents and/or step-parents who are the primary caregiver of the adult participant being served under the Autism Waiver. The relative/legal guardian must be qualified to provide Respite Care services as specified in Appendix C-3:

Payment for the Rent and Food for Unrelated Live-In Caregiver as a waiver service may be made to legal guardians whenever the legal guardian is qualified to provide this service as specified in Appendix C-3

As specified within Appendix D-1-c and D-1-d, each service appearing on the Plan of Care/Cost Comparison Budget (POC/CCB) has been identified through the Individualized Support Plan (ISP), by the Individualized Support Team (IST), as being necessary to meet the needs of the participant. Unilateral decisions are prohibited. As detailed within Appendix B-7-a, the participant maintains the freedom to exercise choice of a new approved provider at any time.

Controls that are employed to ensure that payments are made only for services rendered include the monitoring of services by the Case Manager as described within Appendix D-2 as well as by the BQIS or its contracting vendor as specified within Appendix H. The financial integrity of payments made is also scrutinized as described within Appendix I-1 and I -2-d.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Division of Disability and Rehabilitative Services (DDRS) conducts orientation sessions for all types of prospective providers throughout the year. Orientation sessions are announced via DDRS Bulletins which are posted on the DDRS website. After attending the orientation session, the prospective provider decides whether or not to submit an application within thirty (30) days of the date of orientation.

The application approval process is managed/performed by the DDRS Provider Relations unit. This unit reviews all applications within thirty (30) days of receipt. The prospective provider is then given the opportunity to respond to any questions or additional information requested. The staff is available, upon request, to discuss in person questions regarding the application. The Provider Relations unit works with the potential provider to ensure all required documentation is obtained.

Information regarding the provider approval/enrollment process, provider qualifications required for particular services and other helpful information is also available to prospective services providers on the internet by accessing the Indiana Medicaid HCBS Waiver Provider Manual, the Bureau of Developmental Disabilities Services help line, known as the BDDS Helpline and the Indiana Medicaid HCBS Guide for Consumers (courtesy of the Indiana Governor's Planning Council for People with Disabilities).

Once the provider has successfully completed the application and is approved, DDRS notifies the provider and directs them to contact Indiana's Medicaid fiscal intermediary to enroll as a Medicaid provider. (Medicaid enrollment is required for all waiver service providers.) When the provider is enrolled, DDRS is notified and the provider is added to the active provider data base.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☑ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

(a) Individual budget limits are developed for waiver participants who receive the following services:
• Adult Day Services
• Adult Foster Care
• Day Services
• Residential Habilitation and Support Services
• Respite Care
• Rent/Food of Unrelated Live-in Caregiver
• Applied Behavioral Analysis
• Behavioral Support Services/Crisis Assistance
• Music Therapy
• Occupational Therapy
• Personal Emergency Response System
• Physical Therapy
• Psychological Therapy
• Recreational Therapy
• Family and Caregiver Training
• Specialized Medical Equipment and Supplies
• Speech/Language Therapy
Each individual budget amount for these specific services covers the individual's full year of waiver service.

(b) Individual budget amounts are based upon an assessment of the individual's needs, and the supports required to meet those needs as described in his/her Individualized Support Plan (ISP). The individual Plan of Care/Cost Comparison Budget (POC/CCB) is developed by the case manager with input from the Individualized Support Team (IST) which includes the participant and any of the following persons identified by the participant, case manager, behavioral consultant, providers, friends and family members. Each individual POC/CCB is submitted to and approved by the State's Medicaid Waiver Unit.
For plans of care that were in effect November 1, 2005, the individual budget amount was limited based upon the amount of services that the individual received during the fiscal year period from July 1, 2004 to June 30, 2005 as demonstrated by actual expenditures for each of the composite services that went into the grouped Residential Habilitation and the Day Service definitions. Individual budgets for Plans of Care that have gone through the annual review process since that time have been reviewed by the Individual Support Team and when needed, adjustments have been requested and reviewed by the Waiver Unit.

INDIVIDUAL BUDGET DEVELOPMENT

Unique budgets were computed for each individual waiver recipient, based on the dollars paid to providers for specific services rendered to that individual during State Fiscal Year 2005 (SFY05 = July 1, 2004 – June 30, 2005). The paid claim history was extracted from Indiana's MMIS, and initially included all claims that were processed (paid or approved) as of August 30, 2005. Paid claim amounts were summed, and rates determined, by individual Medicaid RID number. This paid claim history included both positive and negative dollar amounts. Initial rate calculations were executed by an actuarial firm under contract to the State (Milliman), and subsequent rate determinations are being made by the State's Medicaid Waiver Unit.

The INDIVIDUAL RHSA RATE was computed using the following methodology:

This basic rate is composed of two distinct paid claim summary components.
1. Residential Services Component: The first component for typical residential services included the following service codes:
o RHS1 (T2017 U7) – Level 1 – Under 35 hours per week
o RHS2 (T2021 U7 TF) – Level 2 – QMRP for those receiving RHS1
o RHS3 (T2017 U7 TG) – Level 3 – Over 35 hours per week
o IAS (T2017 U7 U1) – Less than 30 hours per month

All paid claim history for each RID was summed to determine an annual rate, and then divided by the estimated number of days of service to establish the billing increment. This amount was then reduced by the following percentage to produce the residential component for RHSA:

Base Daily Rate	Reduction	Recipients Affected	
$.01 – 161.99	0%	2,465	49%
$162.00 – 179.99	1 – 2%	339	7%
$180.00 – 197.99	2 – 3%	344	7%
$198.00 – 249.99	3 – 5%	902	18%
$250.00 – 299.99	6 – 7%	427	9%
$300.00 – 349.99	8 – 9%	299	6%
$350.00 – 449.99	9 – 10%	180	4%
$450.00 – above	0%	25	1%

2. RESIDENTIAL SUPPORTS: This included the following previously existing service codes:
o HCC1 (T2022 U7 U1, T2022 U7 U2, T2022 U7 U3, T2022 U7 U4) – Health Care Coordination at various levels of support.
o TLV1 (T2004 U7 U1), TLV2 (T2004 U7 U2) – Transportation for those in 24 hour supported living settings.
o T1ST (T2004 U7 U3), T2ND (T2004 U7 U4) – Transportation for those in less than 24 hour settings with the service provided by the residential provider
o CHPI (T2021 U7) – Community Based Individual for those that received this service from the residential provider.
All paid claim history for each RID was summed to determine an annual rate, and then divided by the estimated number of days of service to establish the RHSA component.

The resulting amounts for these two components were added together to produce the basic RHSA allotments for each individual served.

The INDIVIDUAL DSRV RATE was computed using the following methodology:

The Day Services rate includes various Community Habilitation and Participation services, vocational supports, and related transportation services. It is a summary of the paid claim history from the following service codes:
o CHPG (T2021 U7 HQ) – Community Based Group
o CHPR (T2021 U7 UA HQ) – Facility Based Group
o CHPF (T2021 U7 UA) – Facility Based Individual
o HPV (T2015 U7) – Pre-vocational services
o HSE (H2023 U7) – Supported Employment
o TD1 (T2004 U7 U6), TD2 (T2004 U7 U8) – Transportation provided by the Day Service provider
o CHPI (T2021 U7) – Community Based Individual for those that received this service from a provider other than their residential provider.

All paid claim history for each RID was summed to determine an annual rate, and then divided by the estimated number of days of service to establish the DSRV allotment for each individual served.

NOTE that CHP – INDIVIDUAL (CHPI) was computed separately so that it could be included with either RHSA or DRSV as noted above. It is the sum total of all paid claim amounts for SFY05 for the service code CHPI (T2021 U7), divided by the estimated number of days of service.

The BMGT and BMG1 RATES were computed using the following methodology:

Both behavioral support services directly correlated (one for one) with previously existing service codes

and both use the same computation methodology. BMGT included all SFY05 paid claims for existing service code BMAN (H004 U7 U2), and BMG1 includes all SFY05 paid claims for BMN1 (H004 U7 U1). The total annual paid claim amount was divided by 12 to produce a base monthly rate, and then multiplied by .92 (8% reduction) to produce the final monthly rate for the BMGT and BMG1 services.

RHSA, DSRV, BMGT and BMG1 RATES for individuals new to the waiver:

These budgets were established by reviewing the assessment and Individual Support Plan information submitted by the case manager and comparing the individual and his/her circumstances to waiver participants with similar needs.

By the end of 2009, Indiana will employ an individual resource allocation process titled "Objective Assessment System for Individual Supports (OASIS) for all waiver participants across all Autism Waiver Services except the Community Transition Services and the Environmental Modification Supports. As described under Appendix D-1, the state contracts with Arbitre to complete the Inventory for Client and Agency Planning (ICAP) assessment. Beginning with the Bureau of Developmental Disabilities Services (BDDS) District 4 in 2008, this process is being phased in as is described under Appendix D-1-d and involves three key factors.

FIRST: Individuals with similar interests and support needs are categorized into participant groups. Defining criteria for these participant groups involves age, predictable life events, family living situation, access to transportation and transportation assistance, health and behavioral support needs, and functional support needs.

SECOND: Service utilization standards are used to determine "usual and typical" service levels for people in each of the participant groups. These service standards are based upon the service utilization experience of a "best practice" sample of waiver participants in the BDDS District 4. "Best practice" standards involve five areas: health and wellness, safety and freedom from harm, stable living situation, access to personal income, and community inclusion / personal satisfaction. These service standards are expressed in amounts of "service units" (such as hours of direct staff support) for each participant group.

THIRD: Standardized fees / reimbursement rates are defined for each HCBS service. These standardized rates are applied to each participant groups' utilization standards which results in the determination of an OASIS annual budget amount (expressed in dollars).

Noting that public input was solicited and considered during the development of the OASIS process, the methodology for determining the budget limits based on level of support amount is also open for public inspection by being posted on the website of Division of Disability and Rehabilitative Services.

(c and d) As described in the Change of Waiver Budget policy [refer to Appendix D-1-d (g)], if a significant change occurs, the resource allocation process (OASIS) will be repeated, including repetition of the Inventory for Client and Agency Planning (ICAP) when necessitated by evidence of a change in condition/skills. After meeting with the Individualized Support Team (IST), the case manager may submit a a revised Plan of Care/Cost Comparison Budget (POC/CCB) which is reviewed and may be approved by the State's Medicaid Waiver Unit.

(e) If an individual has needs that exceed the individual budget allotment, the first recourse is to follow the Change of Waiver Budget policy and request a review of the individual budget amounts. The Case Manager and Individual Support Team will work with the individual to access appropriate Medicaid State Plan services. Where acceptable, Individual Support Teams are encouraged to consider natural supports.

Recognizing that the OASIS is not designed to assess participants whose needs require greater than one-to-one support in a twenty four hour period, the state treats these participants as outliers, considering the recommendations of the Individualized Support Team in determining support needs and annual budget amounts on a case-by-case basis.

(f) Participants are informed of the approved individual budget amounts for all services through the established Notice of Action (NOA). The NOA is generated when the Waiver Unit issues a decision on the individual's Plan of Care. The case manager is responsible for ensuring the individual receives the Notice of Action. Medicaid hearing and appeal rights are included on all Notices of Action.

☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care/Cost Comparison Budget (CCB)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

For individuals receiving services under the Autism Waiver, Case Management is a Medicaid Administrative service and not a Medicaid Waiver service. Case Management is a comprehensive service comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual's care plan. Case Management is required in conjunction with the provision of any home and community–based service and enables an individual to receive a full range of appropriate services in a planned, coordinated, efficient, and effective manner. See Appendix D-1-d for additional and detailed responsibilities of the Case Manager. Appendix D-1-d also outlines the opportunities of the participant to engage and/or direct the process to the extent they wish, explains how those whom the participant wishes to attend and participate in developing the service plan are provided adequate notice, that the planning process is timely, that needs are assessed and services meet the needs, and that appropriate responsibilities of each participant, provider and/or support team member are identified.

CASE MANAGEMENT MINIMUM QUALIFICATIONS state that all case managers providing services must comply with one or more of the qualifications set forth below:

1. Holding a bachelor's degree in one of the following specialties from an accredited college or university:

(a) Social work
(b) Psychology
(c) Sociology
(d) Counseling
(e) Gerontology
(f) Nursing
(g) Special education
(h) Rehabilitation
(i) or related degree if approved by DDRS/OMPP representative

2.. Being a registered nurse with one (1) year experience in human services.

3. Holding a bachelor's degree in any field with a minimum of one (1) year full-time, direct experience working with persons with developmental disabilities.

4. Holding a master's degree in a related field may substitute for required experience.

ADDITIONAL QUALIFICATIONS specific to the duties of the case management functions performed by the contracting entity of case management services and specified within the Indiana Administrative Code are noted as follows:

• 460 IAC 6-5-5 indicates that the case manager must meet the requirements for a qualified mental retardation professional in 42 CFR 483.430(a).

SERVICE STANDARDS
• 460 IAC 6-5-36 indicates that for the Person Centered Planning Process (detailed under Appendix D-1-d), the case manager shall complete the requirements set out in 460 IAC 7-4-1(c) "Development of an Individualized Support Plan (ISP)"; and
• 460 IAC 7-4-1(c) indicates that an ISP shall be developed by an individual's support team using a "person centered planning" process. The support team shall be led by a facilitator chosen by the individual.

The Individualized Support Team (IST) shall be led by a trained facilitator chosen by the individual to collect and complete the profile information of the person centered planning process and development of the ISP. Before functioning as a facilitator of the person centered planning process a facilitator shall:
(1) complete a training provided by a Division of Disability and Rehabilitative Services (DDRS)/Bureau of Developmental Disabilities Services (BDDS) approved training entity or person;
(2) observe a facilitation; and
(3) participate in a person centered planning meeting.

☐ **Social Worker.**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) The Plan of Care/Cost Comparison Budget is developed within the Person-Centered Plan (PCP)/Individualized

Support Plan (ISP) Annual meeting. The participant (individual) and/or family or legal representative are present during this meeting. As described in greater detail under Item D-1-d. (b) and (f), the PCP drives the ISP, which ultimately drives the development of the Plan of Care/Cost Comparison Budget. (The PCP identifies the preferences and non-preferences of the participant, as well as what is important to the participant to accomplish or move toward within a given year. The Individualized Support Plan outlines the participant's identified outcomes and health and welfare needs. The Plan of Care/Cost Comparison Budget is developed based upon the outcomes of the participant and the health and welfare needs of the participant.)

(b) As part of the planning process for the Initial and/or Annual Person-Centered Plan/Individualized Support Plan meeting, the participant designates which persons who know and work with the participant shall be invited to participate in the development and implementation of the participant's ISP. Once the participant identifies the Individualized Support Team members, it becomes the responsibility of the Case Manager to invite the selected support team members to the meeting.

With the phase in and statewide implementation of the OASIS initiative by December 2009 described in Appendix C-4, D-1-d and I-2-a, participants will be advised of the annual budget amount allocated toward the purchase of needed services and supports, enabling the participant and the Individualized Support Team to determine how the funds will be spent toward meeting the identified needs of the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Each service plan, Plan of Care/Cost Comparison Budget (CCB), is developed by the Individualized Support Team (IST) identified by the participant (individual). The participant is the driving entity in the entire process. The CCB is developed a minimum of six weeks prior to the initial start of services or six weeks prior to the end date of the current annual plan of services. The CCB is routinely developed to cover a time frame of 12 consecutive months.

(b) DEVELOPMENTAL DISABILITIES PROFILE (DDP) (for participants age 6 or older): This standardized assessment tool is one of the determinants of the Level of Care process, noting that all Level of Care evaluations are to be completed by a Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR 483.430(a).
1. The initial DDP is completed by the Bureau of Disabilities Services (BDDS) Intake Service Coordinator while subsequent determinations are completed by the Intake and Assessment Specialist of the Indiana Professional Management Group, Inc. (IPMG) once the participant begins receiving services under the Autism Waiver.
2. Each DDP is to be completed with the participant and two reliable informants.
3. The DDP must be completed within one year of the approval date of any Initial CCB and within 90 days of the start date of each Annual CCB.
4. The Case Manager must ensure that the DDP continues to present an accurate assessment of the participant with any update CCB that must be submitted.

DEVELOPMENTAL DISABILIITES PROFILE (DDP) (for children under the age of six): A child may be determined eligible using age-appropriate psychological and developmental assessments. Changes in adaptive functioning can occur frequently in children, therefore eligibility may need to be reviewed again between the ages of six and eighteen if there is a significant change in adaptive functioning. If the child's IQ score has been consistently below 55 on two or more tests administered between the ages of six and eighteen with associated deficits in adaptive functioning, there may be no need for additional testing at age eighteen. Children with IQ scores above 55 and

variations in adaptive functioning may need additional evaluation at age eighteen.

INTAKE AND ASSESSMENT SPECIALIST INTERVIEW: Prior to the Initial, Annual, or subsequent meeting of the IST, an Intake and Assessment Specialist employed by IMPG contacts the participant and/or family members, legal representative, and the Case Manager to identify and/or confirm health and safety needs. (The Meeting Issues & Requirements section of the Participant Support Plan and the high risk assessment are reviewed during this interview.) The results of this interview are reviewed with the entire IST at each Annual meeting. As noted under D-1-d (g) below, information is reviewed at least every 90 days or as changes deem necessary.

HIGH RISK ASSESSMENT: Provider agencies complete a high risk assessment for each participant they serve. The high risk issues (i.e. health, behavioral, physical management, and environmental management) identified through the assessment are then addressed through the agency and potentially through coordination with participant-chosen specialists addressing the various high risk needs.

PERSON-CENTERED PLAN (PCP): As referenced under Item D-1-c (a), the Plan of Care/Cost Comparison Budget is driven by the PCP. As defined within 460 IAC 7-13-12, the PCP allows the participant to direct the planning and allocation of available resources to meet the life goals and needs of the participant by achieving an understanding of how the participant learns, makes decisions, and can be productive. Facilitation of the PCP is the responsibility of the Intake and Assessment Specialist employed by the contracting case management entity, IPMG.

(c) The participant is informed of available Autism Waiver services on an ongoing basis throughout the year. The participant's Case Manager is knowledgeable in all services available under the Autism Waiver through which the participant is purchasing services. Services are determined within each Initial, Annual, or subsequent meeting based upon the participant's outcomes and health and welfare needs identified in the Individualized Support Plan (ISP).

(d) The Plan of Care/Cost Comparison Budget (CCB) is developed based upon a series of activities within each Initial, Annual, or subsequent meeting of the IST, including the PCP and the ISP. This entire process is driven by the participant and is designed to recognize the participant's needs and desires within the facilitation of the PCP and ISP, with the subsequent development of the CCB.

As detailed in Item D-1-d (b) above, the PCP identifies the preferences of the participant, ultimately identifying what the participant determines is important, desires to accomplish or chooses to move toward within a given year.

The PCP:
1. identifies what the participant likes and dislikes,
2. empowers the participant to create a life plan corresponding to the Individualized Support Plan that is based upon the participants preferences, dreams and needs,
3. encourages and supports the participant's long-term hopes and dreams,
4. is supported by a short-term plan that is based on approved costs, given the participant's support needs,
5. includes participant responsibility, and
6. includes a range of supports, including waiver, community and natural supports.

Areas investigated within the PCP include:
1. Advocacy / Self-Determination,
2. Community Participation / Involvement,
3. Employment, Financial / Money Management,
4. Health,
5. Wellness, & Safety,
6. Home/Living,
7. Learning/Education,
8. Leisure/Recreation,
9. Meaningful Day,
10. Relationships, and
11. Rights & Responsibility.

This PCP assessment is facilitated by the Intake and Assessment Specialist employed by IPMG and is completed with the IST identified by the participant. Application of the PCP facilitation process includes:
1. Outlining/mapping the events and activities that occur during a typical week in the life of the participant. This map is to be reflective of an average week.
2. Identifying the preferences, non-preferences, history, current status, potential barriers and maintenance needs of the participant.

3. Creating a Vision Map reflecting the participant's vision for the future, including long and short-term outcomes

The PCP process must occur prior to the development of the initial Plan of Care/Cost Comparison Budget. Thereafter, the PCP process must occur at least annually or more often if there is a significant change in the participant's condition.

The PCP facilitation process is followed by development of the Individualized Support Plan (ISP). The ISP includes both the Outcomes and the Health and Welfare needs identified by the participant (with assistance from the other participant-designated members of the IST), and is based upon the PCP. The Plan of Care/Cost Comparison Budget is then developed. The entire Plan of Care/Cost Comparison Budget process is based upon the needs of the participant, as identified by the participant.

Note that as Indiana moves forward with the CMS approved phase of the Objective Assessment System for Individual Supports (OASIS) cited within Appendix C-4, Indiana will be using the Inventory for Client and Agency Planning (ICAP) assessment tool within the shadowing and piloting phases of the program. The ICAP will continue to be administered via contract with Arbitre Consulting, Inc.

Results of the ICAP assessment, in conjunction with additional factors including the age of the participant, living arrangements, and geographical location of the participant are all considered toward the determination of the annual budget amount allocated to each participant served under the Autism Waiver. The Case Manager and members of each participant's IST will be advised of the annual budget amount so that the team may choose how best to spend the annual allocation in meeting the identified needs of the participant. Best practice guidance will be provided to each participant and IST in regard to other participants with similar needs, but the ultimate decision regarding the types and amounts of services and supports purchased will rest upon the participant and the IST.

The phase in of the OASIS project began with participants served within the BDDS District 4. The phase in and implementation will continue on a statewide basis by administration of the ICAP under the OASIS system as the annual anniversary date of each participant comes due and participants in all eight BDDS Districts state-wide are assessed. Additional information regarding the OASIS system is available within Appendix I-2.

(e) The coordination of Waiver and other services is the responsibility of the Case Manager and will remain so as the OASIS initiative is phased in and fully implemented by December 2009. Within 30 days of implementation of the service plan, the Case Manager is responsible to ensure that all identified services and supports are in place as identified within the Individualized Support Plan and the Plan of Care/Cost Comparison Budget. The Case Manager is responsible to monitor and coordinate services on an ongoing basis and, to prevent lags, must record a weekly case note for each participant served, whether or not actual contact with the participant has occurred. A formal review of services shall be completed by the Case Manager at least every 90 days, or more often as circumstances may dictate.

Documentation standards exist for each service provided under the Autism Waiver. Included within these standards is the requirement that each service provider submit to the Case Manager, either a monthly or quarterly report identifying the level of support provided to the participant based upon the support and service needs identified within the ISP and the CCB.

(f) The ISP identifies the services needed by the participant to pursue the desired outcomes and to address the health and safety needs of the participant. Each outcome within the ISP has associated strategies addressing potential barriers or maintenance needs in relation to the Outcome. The strategy identifies the support needed by the participant to pursue the participant-identified desired Outcome. The strategy also identifies the Responsible Party, including the name of the agency, the Waiver service code, and the name of the position responsible for the Strategy. The participant may elect to be named as the Responsible Party for a Strategy. In addition, each Strategy has a specific timeframe identified, including a minimum review timeframe for each Strategy.

For each Waiver service listed on the Plan of Care/Cost Comparison Budget (CCB), the CCB identifies:
1. the name of the Waiver service, the name of the Participant-chosen service provider,
2. the unit cost of the service,
3. the number of units of the service, as well as
4. the start and end dates for the service.

See Item D-1-d (e) above regarding documentation standards for each service under the Waiver. As stated above, the Case Manager is responsible to review each service and document the progress made by each service in supporting the participant toward the outcomes. This progress is documented within the formal 90 day checklist and within the

Progress Notes of the ISP a minimum of every 90 days. This process is not changing with the phase in or statewide implementation of the OASIS initiative.

(g) The Plan of Care/Cost Comparison Budget (CCB) is updated a minimum of every 365 days. To prevent lags, the Case Manager must record a weekly case note for each participant served, whether or not actual contact with the participant has occurred. The participant can request a change to the CCB at any point; be it a new service provider, or a change in the type or amount of service. The Individualized Support Plan (ISP) is reviewed a minimum of every 90 days. If a change of the ISP and/or of the CCB is indicated, the participant and/or guardian/legal representative and Individualized Support Team (IST) will meet to discuss the change. The actual updating of the CCB is completed by the Case Manager based upon the decision of the participant with the IST. The State reviews the request for change based upon the "Change of Waiver Budget during the Annual Plan Year" Policy. This process is not changing with the phase in or statewide implementation of the OASIS initiative.

(h) The participant may request a change of service, service provider, or service amount at anytime during the annual plan year. This process is not changing with the phase in or statewide implementation of the OASIS initiative.

Note: In the event that circumstances prohibit either the timely creation or approval of the Annual CCB, a temporary, 2-month extension of the most recently approved CCB is auto-generated and auto-approved by the state's electronic case management data system while sending notification of the approval to continue services (as they currently exist) to the Case Manager and to all providers of current services listed on the CCB via the Notice of Action (NOA). At the same time, the State generates a report identifying all temporarily extended CCBs. The report is relayed to the contracting case management entity, Indiana Professional Management Group, Inc. (IMPG), by the DDRS Case Management Liaison position. The IPMG then distributes the report to the appropriate regional directors within the contracting agency so that the delays may be promptly addressed by the appropriate Case Manager(s). The creation of additional temporarily extended budgets occurs as needed to ensure the services and supports required by the participant continue until such time that the Annual CCB is created, submitted, and approved. The DDRS Case Management Liaison position works closely with the IMPG directors to identify, address and eliminate the systemic issues within the contracting entity which have resulted in the need for the temporary, extended budgets.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks are assessed by and through the Plan of Care/Cost Comparison Budget (CCB) development process outlined under D-1-d (b) above. Risk assessment and mitigation strategies are addressed by the Individualized Support Team (IST) designated by the participant and are facilitated during the Initial, Annual, or subsequent meeting(s) of the IST by the Intake and Assessment Specialist employed by the contracting entity of case management services, Indiana Professional Management Group, Inc. (IPMG).

The participant's Individualized Support Plan (ISP) is developed by the IST as explained under Appendix D-1- d. Any identified high risk issues are addressed through participant-specific high risk plan(s) to proactively and reactively address the risk issue. The ISP must identify and mitigate risks associated with the health and welfare of the participant, with strategies and action plans addressing relevant issues such as seizure management, behavior management and interventions, medication side effects, diet and nutrition, swallowing difficulties, crisis control and management, significant health concerns as well as physical environmental issues. The risk assessment also identifies when the personal choice(s) and preferences of the participant may lead to circumstances in which the participant is subject to potential abuse, neglect or exploitation.

During scheduled meetings of the IST and at the frequency specified within the ISP, team members review the high risk issues and ensure that the risk plan(s) in place are effective and efficient toward supporting the participant in regard to the identified risk, while considering and respecting the needs and preferences of the participant. All risk

plans are identified in the Individualized Support Plan, which drives the Plan of Care/Cost Comparison Budget. (Refer to Appendix D-1-d for service plan development details) The Plan of Care/Cost Comparison Budget addresses high risk areas specifically within the Emergency Back-Up Plan section of the CCB.

With the agreement of the IST and as reflected within the ISP, a participant may exercise the right to personal choice and preference in regard to the management of risk(s). The course of action is determined by the participant and other Individualized Support Team members designated by the participant.

The participant may choose to:
• assume personal responsibility for implementing team-identified strategies toward mitigation of the risk and toward taking the agreed course of action(s) in risk management, or
• delegate these responsibilities to others, such as support team members or direct care providers, or
• share these responsibilities with others as identified within the ISP

When individuals are supported in their own private residence or other settings where staff might not be continuously available, the service plan includes a back-up plan to address contingencies such as emergencies, including the failure of a direct caregiver to appear when scheduled to provide necessary services. Back-up plans are specified within the plan of services (CCB) and may include such arrangements as telephone calls to family, friends, neighbors, police, or 911 emergency responders, walking to the home of a neighbor, or the use of a Personal Emergency Response System when approved by the participant's IST. Appropriate emergency telephone numbers are posted in the home of each participant.

Note that when the ISP and CCB indicate a participant is to be served in a 24 hour, 7 days per week setting, direct care staff member(s) is/are prohibited from leaving the setting until the direct care provider responsible for the next shift has arrived. Each provider is required to establish a plan and utilize a process to ensure the health and welfare of the participant in the event a direct care staff member fails to report to for a shift. For example, such plans may require management personnel from the provider agency cover the shift until a trained direct care staff member arrives.

Indiana Professional Management Groups (IPMG) maintains a 24-hour per day emergency response system that does not rely upon the area 911 system and provides assistance to all participants.

Additional strategies toward the management of risk include protections which are built into the Indiana Administrative Code governing the supported living supports and services for individuals with developmental disabilities and required of all approved providers of services and supports. Each service provider is accountable to ensure that:
• Per 460 IAC 6-9-4, "Systems for Protecting Individuals", at regular intervals specified within the ISP, participants must be advised of the risk of treatment.
• Per 460 IAC 6-10-10, "Quality Assurance and Quality Improvement Systems", each provider is responsible to have and utilize an internal process for analyzing data related to incidents, developing recommendations toward reducing the risk of future incidents and reviewing these recommendations to determine their effectiveness.
• Per 460 IAC 6-18-2, "Behavioral Support Services", if medications are administered to the participant by the provider, the provider must analyze medication errors, develop recommendations toward the reduction of future medication errors and review these recommendations to determine their effectiveness.
The Bureau of Quality Improvement Services monitors provider compliance with these and other factors as is identified within Appendices G and H.

Risk assessment and mitigation will not change as a result of phase in or statewide implementation of the OASIS initiative.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The participant may request a change of service provider at anytime while receiving services under the Autism Waiver. Upon request, the Case Manager shall assist the participant with obtaining information about any and all

qualified and available providers of a given service. An electronic case management database maintained by the State contains information regarding all qualified providers for each service offered under the Autism Waiver. Case Managers are able to generate a comprehensive list of qualified providers specific to each service offered under the Autism Waiver for the participant's use.

Case Managers can assist the participant in contacting, interviewing and/or obtaining references on the potential providers, as desired by the participant. Case Managers shall not offer personal or professional opinions in regard to any provider of Autism Waiver services. The Case Manager is responsible to coordinate the transition of services from any existing service provider(s) listed on the current Plan of Care/Cost Comparison Budget (CCB) to any replacement service provider(s) as determined by the participant's choice.

The methods by which participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan will not change as a result of the phase in or statewide implementation of the OASIS initiative.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

Specify the other schedule:

The plan is updated a minimum of every 365 days. However, the Individualized Support Plan and Plan of Care/Cost Comparison Budget (CCB) are formally reviewed a minimum of every 90 days by the Case Manager in conjunction with the participant's Individualized Support Team. The participant can request a change to the CCB at any point; be it a new service provider, or a change in the type or amount of service.

This process will not change with the phase in or statewide implementation of the OASIS initiative.

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Electronic facsimiles of the Plan of Care/Cost Comparison Budget are also maintained by the contracting entity of Case Management Services, Indiana Professional Management Group, IPMG.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case Managers are responsible for the implementation and monitoring of the service plan and participant health and welfare. A minimum of one face-to-face contact between the Case Manager and the participant is required every 90 days, and as frequently as needed to support the participant. In each meeting the individual's support team will review current concerns, progress and implementation of the plan of care.

In addition, there are required pieces of information that must be documented every 90 days. This is referred to as the 90 Day Checklist. With each completion of the 90 Day Checklist, the Case Manager and Individualized Support Team cover in detail the status of Cost Comparison Budget, the Individualized Support Plan, any behavioral support program, choice and rights, medical needs, medications, psychotropic medications, seizure management (if applicable), nutritional/dining needs, health and welfare, incident review, staffing issues, fiscal issues, and any other issues which may be identified in regard to the satisfaction of the participant

The case manger also has weekly contact with the individual and family/guardian through home and community visits or by phone to monitor progress and implementation of the plan of care and to address any immediate needs. The Case Manager also maintains frequent contact with the provider of services to coordinate care and to monitor progress and implementation of the plan of care. During each of these contacts the Case Manager assesses the plan of care implementation as well as monitoring needs.

The monitoring and follow up method used by the Case Manager include conversations with the individual served, the parent/guardian, and providers to monitor the frequency and effectiveness of the services through monthly team

meetings and weekly face-to-face and phone contacts. The Case Manager asks:
• Are the services being rendered per the plan of care?
• Are the service needs of the individual being met?
• Do individuals exercise freedom of choice of providers?
• What is the effectiveness of crisis and back up plans?
• Is the individual's health and welfare being assured?
• Do individuals have access to non-waiver services identified in the plan of care including access to health services?
The implementation and effectiveness of the plan of care is reviewed in quarterly team meetings.

A monitoring report will be developed by Indiana Professional Management Group (IPMG) and sent to the DDRS Case Management Liaison, DDRS management staff and to the Office of Medicaid Policy and Planning (OMPP) on a quarterly basis for review. Full, immediate and unrestricted access to the individual data shall be available to the State, including the DDRS Case Management Liaison position as well as other members of the DDRS Executive Management Team and OMPP as needed.

A minimum 5% random sample of service plans will be reviewed annually by the Bureau of Quality Improvement Services to assure consistency of waiver Plan of Care/Cost Comparison Budget with the Individualized Support Plan.

Service plan implementation and monitoring will not change with the phase in or statewide implementation of the OASIS initiative.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

During the Bureau of Developmental Disabilities Services' (BDDS) Intake and Assessment Process, the applicant for services under the Autism Waiver (or his/her legal representative) shall be advised of all available service options as well as their appeal rights at each decision. The BDDS Service Coordinator (SC) provides Intake Case Management Services, which includes offering an eligible applicant the feasible alternatives available under the Autism Waiver and the choice between institutionalization or home and community-based services as described in Appendix B-7a.

Following is a description of how the individual (or legal representative) is offered the opportunity to request a Fair Hearing under 42 CFR PART 431, SUBPART E:

The Notice of Action (State Form 46015 Form 5): Federal regulations for the Medicaid program (42 CFR 431.200) require that each Medicaid applicant/recipient be informed of any action that affects the individual's Medicaid benefits. An "Action" may be a termination, reduction, or suspension of eligibility or any amount of covered services. This also includes actions taken to approve or deny new applicants as well as the choice of waiver or institutional services and the choice of providers. State Form 46015 Form 5 is used to notify each Medicaid Waiver applicant/participant of any action that affects the individual's Medicaid Waiver benefits. An explanation regarding a waiver service participant's appeal rights and the opportunity for a fair hearing is found on the back of the form. Part 2 "Your Right to Appeal and Have a Fair Hearing" advises individuals of their right to appeal and the timely actions which are required. Part 3 "How to Request an Appeal" provides instructions for individuals regarding the procedures that are necessary in the appeal process, including the right of the appellant to authorize representation by an attorney, relative or other spokesperson on behalf of the appellant.

Once an applicant enters the waiver program as a participant, the participant retains the same appeal rights and right to a Fair Hearing as described above. The participant shall be advised of the Right to Appeal and have a Fair Hearing by the Case Manager (CM) employed by the contracting entity, Indiana Professional Management Group, Inc. (IPMG).

The CM shall provide each participant and eligible individual (and the individual’s guardian or advocate, as appropriate) with a copy of the Notice of Right to Appeal and have a Fair Hearing. The notice shall be immediately provided to the participant when the individual is not provided the choice of home and community-based services as an alternative to institutional care, when the individual is denied the service(s) of their choice or the provider(s) of their choice, or when actions are taken to deny, suspend, reduce or terminate services.

The waiver Notice of Action informs the participant (and the participant's guardian or advocate, as appropriate) of his/her right to an appeal. The Notice of Action also advises the participant that services will be continued if he/she files the appeal in a timely manner, which is within 30 days of the decision date noted on the Notice of Action.

Upon request, the CM shall assist the eligible participant in preparing the written request for Appeal and Fair

Hearing. Timeframes, the address for submission of the appeal, and an opportunity to discuss the issue being appealed shall be offered to the eligible participant by the CM. The request for an Appeal and a Fair Hearing is kept on file within the participant's record in the electronic data system of the contracting case management entity, IPMG, and at the Family and Social Services Administration Hearing and Appeals office.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Indiana Division of Disability and Rehabilitative Services (DDRS) operates a separate dispute resolution process in addition to the formal, federally required Hearings and Appeals process toward addressing participant disputes or disputes involving the needs of the participant. In general, this process is available when there are disagreements about service provision. Resolution of the dispute is designed to address the individual's needs. Any issues that involve an individual's health and welfare do not go through this process, but are immediately referred to the Bureau of Quality Improvement Services (BQIS) for action.

The Indiana Administrative Code 460 IAC 6-10-8, "Resolution of Disputes" clarifies the responsibilities and timeframes for all parties involved in a dispute. It is recognized that this process was designed to handle disputes between providers, however, in those situations where Individualized Support Teams(IST) can not come to agreement on how best to meet the needs of the individual, the Dispute Resolution process is available.

The beginning point of this process is the IST meeting in which parties are required to submit their issues in writing to the team. If providers on the Team are in agreement, and the individual or family member is not, the Case Manager (CM) must represent the individual in the Dispute Resolution process. If the team is unable to come to agreement on a decision within fifteen days, the dispute is referred to the appropriate Bureau of Developmental Disabilities (BDDS) Service Coordinator (SC) within the DDRS. The guiding standards for the SC in settling disputes will be the outcomes established for the individual in the Individualized Support Plan (ISP) and the health and welfare needs of the individual.

The SC is required to make a decision on the issue within fifteen days of the referral. Written notice is given to relevant parties. Any party adversely affected by the decision may request DDRS Administrative Review of the decision. While the dispute resolution process is available for teams to use, it is not required before an individual or guardian can file the request for a Medicaid Fair Hearing. As noted within 460 IAC 6-19-4 Distribution of information and 6-19-6 Monitoring of services, the CM is responsible for the monitoring of services and ensuring that the participant understands that the dispute process is in no way a pre-requisite or substitute of the participant's right to Appeal or request a Fair Hearing.

Unilateral decisions about service provision restrict the creative abilities of the IST to design a plan of care that recognizes the realities of everyday life, including the limited financial resources available from the State, to maximize the ability of the individual to achieve their outcomes. The IST, and not any one member, must drive decisions related to change in service. However, neither should any single individual of the team unilaterally refuse to agree to changes in the plan. Any service changes that occur must be done in accordance with the direction and agreement of the IST.

If it is determined the provider's unilateral actions have endangered the health or welfare of an individual such that an emergency exists, BDDS will take action as described in rule 460 IAC 6-7-4, "Serious Endangerment of the

Individual's Health and Safety (Welfare)".

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

1. The operating agency, the Division of Disability and Rehabilitative Services (DDRS), operates a separate complaint process system through the Bureau of Quality Improvement Services (BQIS) [established in Indiana Code, IC 12-12.5] in conjunction with the Bureau of Developmental Disabilities Services (BDDS) [established in IC 12-11-1.1] and in addition to the formal, federally required Hearings and Appeals process.

2. Satisfying the requirements of Indiana Code [IC 12-11-13], the operating agency, DDRS, also employs a statewide waiver ombudsman, independent of both the BQIS and the BDDS, for the benefit of participants with a developmental disability who are receiving services under the waiver and wish to file a complaint.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

1. The Bureau of Quality Improvement Services (BQIS) ensures that all complaints are addressed in a timely manner to assure the health and welfare of individuals receiving services administered through the Bureau of Developmental Disabilities Services (BDDS). Complaints may be filed by participants, guardians, case managers, providers and employees of providers.

To file a formal complaint, individuals may call 1-800-545-7763, email any BQIS or BDDS employee, or mail their complaint to Complaints, BQIS, 402 W. Washington Street, Room W451, Indianapolis IN 46207. Complaints may also be filed with a BDDS Service Coordinator who will formally file the complaint with BQIS.

This complaint process documented within 460 IAC 6-7 Monitoring; Sanctions; Administrative Review is summarized as follows:

Upon receipt of a complaint, BQIS determines whether the case manager, provider and/or BDDS District Office are aware of the perceived problem, and in situations that health and welfare are not affected, given an opportunity to resolve the issue. If not, the complaint is communicated to the appropriate entity for resolution at the local level. If the issue is not resolved satisfactorily at the local level, the issue is considered a formal complaint.

FORMAL COMPLAINTS – ROUTINE. The BQIS Complaints Director assesses all formal complaints within 3 days of receipt and attempts to resolve the issue. The Complaints Director will determine if a formal incident report needs to be filed (as discussed in Appendix G-1-a.) The Complaints Director investigates the complaint by conducting interviews and site visits when appropriate or will refer for formal investigation to Adult Protective Services, Child Protective Services, law enforcement, the Indiana Attorney General or a BQIS investigator. BQIS determines if the complaint is fully or partially substantiated, or not substantiated. The BQIS Complaints Director will require the provider to complete a plan of correction with deadlines for implementation for complaints fully or partially substantiated.

FORMAL COMPLAINTS – HEALTH and WELFARE ISSUE. The BQIS Complaints Director assesses all formal complaints involving the health and welfare of the participant within 1 day of receipt and attempts to resolve the issue. The Complaints Director will determine if a formal incident report needs to be filed (as discussed in Appendix G-1-a.) The Complaints Director will investigate the complaint by conducting interviews and site visits when appropriate or will refer for formal investigation to Adult Protective Services, Child Protective Services, law

enforcement, the Indiana Attorney General or a BQIS investigator. BQIS determines if the complaint is fully or partially substantiated, or not substantiated. The BQIS Complaints Director will require the provider to complete a plan of correction with deadlines for implementation when a complaint is fully or partially substantiated. More serious issues regarding health and welfare have shorter implementation timelines.

The Complaints Director enters all details into the Complaint Investigation & Resolution System (CIRS) including name of the individual receiving services, date, time, means of referral (e-mail, letter, etc.), and issues involved; sends acknowledgment to complainant of receipt of complaint, including name and contact person's information; documents actions in CIRS; and establishes hard copy complaint file which includes the case ID # from CIRS.

The Complaints Director will advise the participant that the complaint process is not a pre-requisite or a substitute of a Medicaid Fair Hearing when the problem falls under the scope of the Fair Hearing process described in Appendix F-1.

2. The role of the statewide waiver ombudsman is to receive, investigate and attempt to resolve complaints and concerns that are made by or on behalf of individuals who have a developmental disability and who receive services under a waiver under the home and community-based services program. Complaints received via the toll free number 1-800-622-4484, via e-mail, in hard copy format or by referral to the statewide waiver ombudsman include complaints initiated by families and/or participants, complaints involving rights or issues of participant choice, complaints requiring coordination between legal services, operating agency services and provider services.

The ombudsman is expected to initiate contact with the complainant as soon as possible once the complaint is received. However, precise timelines for the final resolution of each complaint are not established. While it is expected that the ombudsman diligently and persistently pursue the resolution of each complaint determined to require investigation, it is recognized that circumstances surrounding each investigation vary. Timeframes toward complaint resolution vary in accordance with the required research, in the collection of evidence and in the numbers and availability of persons who must be contacted, interviewed, or brought together toward the resolution of the complaint. Therefore, specific timelines for resolution of each complaint are not assigned. The DDRS Director is responsible for oversight of the statewide waiver ombudsman.

With the consent of the participant having a developmental disability, the statewide waiver ombudsman must be provided access to the participant, any entity that provides services to the participant and records of the participant, including records held by the entity providing services to the participant. When the participant is determined by the attending physician or by state law to be incapable of giving consent, the statewide waiver ombudsman must be provided access to the name, address and telephone number of the participant's legal representative.

A provider of waiver services or any employee of a provider of waiver services is immune from civil or criminal liability and from actions taken under a professional disciplinary procedure for the release or disclosure of records to the statewide waiver ombudsman.

A state or local government agency or entity that has records relevant to a complaint or an investigation conducted by the ombudsman shall provide the ombudsman with access to the records.

The statewide waiver ombudsman shall promote effective coordination among the programs that provide legal services for individuals with a developmental disability, the operating agency, providers of waiver services to individuals with developmental disabilities, and providers of other necessary or appropriate services; and ensure that the identity of the participant will not be disclosed without either the participant's written consent or a court order.

At the conclusion of an investigation of a complaint, the ombudsman shall report the ombudsman's findings to the complainant. If the ombudsman does not investigate a complaint, the ombudsman shall notify the complainant of the decision not to investigate and reasons for the decision.

The statewide waiver ombudsman shall prepare a report at least annually (or upon request) on the operations of the program. A copy of the report shall be provided to the governor, the legislative council, the operating agency and the members of the Indiana Commission on Mental Retardation and Developmental Disabilities. Note that trends are identified so that recommendations for needed changes in the service delivery system can be implemented.

The operating agency is required to maintain a statewide toll free telephone line continuously open to receive complaints regarding waiver participants with developmental disabilities. All complaints received from the toll free line must be forwarded to the statewide waiver ombudsman, who will advise the participant that the complaint process is not a pre-requisite or a substitute of a Medicaid Fair Hearing when the problem falls under the scope of

the Medicaid Fair Hearing process described in Appendix F-1.

A person who intentionally prevents the work of the ombudsman, knowingly offers compensation to the ombudsman in an effort to affect the outcome of an investigation or a potential investigation; or knowingly or intentionally retaliates against a resident, a client, an employee, or another person who files a complaint or provides information to the ombudsman; commits a Class B misdemeanor.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State requires reporting of any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual.

Reportable incidents include the following:

1. Incidents of suspected abuse or neglect of an adult or child who is residing in a community residential setting. All incidents falling in this category must also be reported to Adult Protective Services or Child Protective Services (withing Department of Children's Services).

a) Physical, sexual, verbal or mental abuse
i) physical- includes willful infliction of injury, unnecessary physical or chemical restraints or isolation, and punishment with resulting physical harm or pain
ii) sexual - includes all allegations of rape, sexual misconduct, or sexual exploitation
iii) verbal - includes oral, written, and/or gestured language that includes disparaging and derogatory remarks to consumers
iv) mental - includes unreasonable confinement or intimidation

b) Neglect - includes failure to provide appropriate care, food, medical care or supervision

2. Exploitation. All incidents falling in this category must also be reported to Adult Protective Services or Child Protective Services (within the Department of Children's Services).

a) Financial - any deliberate misplacement, exploitation, or wrongful temporary or permanent use of an individual's belongings or money.
b) Any other type of exploitation, including but not limited to sexual exploitation.

3. Death of an individual. All deaths must also be reported to Adult Protective Services or Child Protective Services (within the Department of Children's Services).

4. A residence that compromises the health and welfare of an individual due to a significant interruption of a major utility, such as electricity, heat, water, air conditioning, plumbing, fire alarm or sprinkler system.

5. Environmental/structural problems associated with a habitable residence that compromise the health and welfare of an individual, including inappropriate sanitation, serious lack of cleanliness, rodents, structural damage, or damage caused by flooding, tornadoes or other acts of nature.

6. Residential fire resulting in relocation, personal injury, property loss or other issues.

7. Missing persons

8. Any suspected criminal activity by staff members or individuals, including but not limited to theft, illegal drug use, and arson.

9. Any medical or psychiatric treatments/services (including emergency room visits) that resulted from events that had a potential for causing significant harm or injury or that require medical follow-up.

10. Admission to a nursing facility, including respite stays.

11. Injuries of unknown origin.

12. Significant injuries including:

a) Injuries incurred while individual was restrained
b) Fractures
c) Burns greater than first degree
d) Choking
e) Large areas of contusions or lacerations

13. Medication errors.
NOTE: refusal to take medications does not constitute an error and does not require filing of an incident report but should be followed up by medical personnel and the interdisciplinary team to ensure that the health and welfare of the individual is safeguarded. This information should also be documented in the individual's record.

a) Wrong medication given that places an individual's health and welfare in jeopardy as determined by the personal physician.
b) Wrong dose given that places the individual's health and welfare in jeopardy as determined by the personal physician.
c) Missed medication that places the individual's health and welfare in jeopardy as determined by the personal physician.
d) Medication given outside the prescribed administrative window that jeopardizes an individual's health and welfare as determined by the personal physician.

14. Inadequate staff support resulting in or having the potential to result in significant harm or injury to an individual or death of an individual. This includes inadequate supervision by staff, even when staffing levels are appropriate.

15. Inadequate medical support, including failure to obtain needed follow up medical appointments, failure to obtain routine or special dental or physician appointments, or failure to obtain medication refills in a timely manner.

16. Use of any “pro re nata” PRN (as needed) medication related to an individual's behavior.

All incident Report forms are to be completed within 24 hours of the occurrence being identified. Follow-up reports are to be submitted within 7 days and continuing every 7 days thereafter until resolved.

Under IAC 460-6-9-5, "Incident Reporting", all funded service providers, their employees or agents, are required to report incidents falling within these categories within 24 hours of the incident, or gaining knowledge of the incident. The Division of Disability and Rehabilitative Services (DDRS) Incident Reporting Policy extends the reporting requirement to Case Managers, BDDS and Bureau of Quality Improvement Services (BQIS) staff. The reporting requirement is consistent across age groups.

Incident reports and subsequent follow-up reports are also required to be provided to the participant’s case manager, legal guardian if applicable, and the service provider, under BDDS’ Incident Reporting policy. Incidents of alleged or suspected abuse, neglect, or exploitation must also be reported to Indiana Adult Protective Services or Child Protective Services (within the Department of Children's Services) as applicable based on age.

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Each individual’s home is to have the phone number of the state Developmental Disabilities (DD) Ombudsman and it is the responsibility of the residential provider to assure that this number is available. The Case Manager is the primary contact for waiver participants, and has the primary role for monitoring for exploitation, abuse and neglect. Providers are required as a part of 460 IAC 6 -8-3, "Promoting the Exercise of Rights", and 460 IAC 6-9-2, "Adoption of Policies and Procedures to Protect Individuals", to have policies and procedures in place regarding

participant rights and those are provided to all waiver participants.

To better ensure that participants and their families and/or legal representatives receive training on protections from abuse, neglect, and exploitation, the DDRS will, in early 2008, undertake changes to the Case Management 90-day Checklist to include verification that emergency contact information is in place in the home, and that the telephone numbers for Adult Protective Services or Child Protective Services, and the Bureau of Quality Improvement Services are included in this list. Additionally, the Case Manager will give examples of situations when the contact numbers should be called. This verification will be performed with the participant by the Case Manager at each 90 day review.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

All reports of critical incidents are received and reviewed by the Bureau of Quality Improvement Services. Reports are reviewed by Qualified Mental Retardation Professional (QMRP)-level Incident Reviewers within 24 working hours of receipt for level of severity, level of follow-up required, and to assure that required notifications are made, including reporting to Indiana Adult Protective Services or Child Protection Services. Reports are coded by incident type and the level of follow-up required. Follow-up is required when appropriate steps were not taken, nor systems in place to avert a negative outcome, and there is a chance of a similar incident reoccurring with that individual or others in the same care setting. When follow-up is required, the entity responsible for follow-up is required to submit a follow-up report within 7 days of the initial incident report. The incident report reviewers review follow-up reports to determine if an incident has been substantially resolved, and steps taken to prevent future occurrences. Follow-up reporting is required every 7 days until the incident is deemed resolved by the reviewer. For incidents involving waiver participants, the entity responsible for conducting an investigation is the waiver provider.

The state does not provide a standardized protocol or timeframe for conducting an investigation, but 460 IAC 6-9-4, "Systems for Protecting Individuals", requires:
A provider shall establish a protocol specifying the responsibilities of the provider for:
(1) conducting an investigation; or
(2) participating in an investigation of an alleged violation of an individual's rights or a reportable incident. The system shall include taking all immediate necessary steps to protect an individual who has been the victim of abuse, neglect, exploitation, or mistreatment from further abuse, neglect, exploitation, or mistreatment.

Written follow-up and oversight of the resolution process is the responsibility of the waiver Case Manager.

In addition to requiring follow-up, the Incident Reviewer may designate the incident as a Sentinel Event. A Sentinel Event is any "…unexpected occurrence involving serious physical or psychological injury or the risk thereof. Serious injury specifically includes a loss of limb or function. The phrase 'or risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious outcome." Notification of Sentinel status is made via e-mail to the appropriate BDDS District Manager and the Office of Medicaid Policy Planning. Sentinel status requires the BDDS Service Coordinator to contact appropriate entities within 24 business hours of notification to assure that health and welfare needs are being met and the support team is working towards prevention of future occurrences. Documentation of sentinel event resolution activity is reviewed by the BQIS Incident Reporting Supervisor on a weekly basis, closing sentinel status when BDDS has documented health and welfare assurances. Investigatory and follow-up responsibilities by the provider and case manager, respectively, are not changed by the sentinel designation, closure of sentinel status, or by BDDS's responsibilities in the sentinel event resolution process.

Incident reports and subsequent follow-up reports are also required to be provided to the participant's case manager, legal guardian if applicable, and the service provider, under BDDS' Incident Reporting policy. Incidents of alleged or suspected abuse, neglect, or exploitation must also be reported to Indiana Adult Protective Services or Child Protective Services (within Department of Children's Services) as applicable based on age.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Bureau of Quality Improvement Services (BQIS) is responsible for oversight of the incident reporting system and process. DDRS shares a website with the Indiana Division of Aging dedicated solely to the submission of incident reports and accessible to anyone wishing to file a report. DDRS providers are required to submit incident

reports through the website. Faxed or e-mailed reports are accepted in exceptional situations or with the approval of BQIS. The oversight function begins with the review of the incident report and the initial plan to resolve the incident when provided. Incidents requiring follow-up are not closed until the Reviewer determines that risks to health and welfare have been resolved. Until that determination is made, follow-up is required every 7 days. Notification of the reviewer's determination is made via e-mail for each follow-up report.

All sentinel events are reviewed on a weekly basis by the BQIS Incident Reporting Supervisor. When documentation assuring health and welfare is confirmed, Sentinel status is closed. The Incident Reporting Supervisor distributes a weekly report of unresolved sentinel events to the Office of Medicaid Policy and Planning (OMPP), BDDS and BQIS directors for administrative monitoring and follow-up. The Incident Reporting Supervisor also generates and distributes a monthly report identifying the response time for each sentinel event, and an average response time for each BDDS district.

Aggregate incident data is compiled by the Incident Reporting Supervisor. "High-Risk Incident" reports are distributed to BDDS districts on a monthly basis for analysis and remedial action by BDDS service coordinators and the local risk management committees. These reports identify, by individual and provider, incidents of choking, bowel impaction, seizures requiring medical intervention, falls of a serious nature, dehydration, self-injurious behavior, elopement, respiratory events, "pro re nata" PRN (as needed) medications, abuse, consumer aggression, exploitation, neglect, and sentinel events. Additional reports and trend-lines are developed for statewide data, distributed to BDDS and BQIS administration, and analyzed by the State Risk Management Committee and the Quality Improvement Executive Committee. Additional reports include incident closure and sentinel closure elapsed-time reports, incident-category analysis and reports by funding source.

The State Risk Management Committee and the Quality Improvement Executive Committee (QIEC) have the responsibility to analyze trends and develop remedial strategies. The State Risk Management Committee meets bi-monthly and is composed of representatives from the BQIS mortality review, incident reporting, and surveying programs, Outreach Services, Crisis Services, OMPP, and other representatives within DDRS. The QIEC meets monthly and is composed of representatives from DDRS and OMPP, as well as representatives from providers, advocates and self-advocates.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

- **The State does not permit or prohibits the use of restraints or seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

- **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

  i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  The State allows the use of restraints when used in conjunction with a Behavioral Support Plan, or in an emergency situation "only to prevent significant harm to the individual or others." Indiana code applicable to waiver services does not differentiate between personal restraints and mechanical restraints, but includes them as "restrictive interventions" in its implementation of safeguards. Drugs used as a method of restraint are also addressed as a "restrictive intervention" while requiring additional safeguards. Seclusion is not allowed as a behavioral intervention and is considered an act of abuse.

460 IAC 6-18-2, "Behavioral Support Plans", allows behavioral support plans which utilize restrictive interventions when the plan contains:
(1) A functional analysis of the targeted behavior for which a highly restrictive procedure is designed;
(2) documentation that the risks of the targeted behavior have been weighed against the risk of the highly restrictive procedure;
(3) documentation that systematic efforts to replace the targeted behavior with an adaptive skill were used and found to be not effective;
(4) documentation that the individual, the individual's support team and the applicable human rights committee agree that the use of the highly restrictive method is required to prevent significant harm to the individual or others;
(5) informed consent from the individual or the individual's legal representative;
(6) documentation that the behavioral support plan is reviewed regularly by the individual's support team. The individual's support team participates in quarterly reviews with the behavioral support staff. The team reviews provider monthly reports, behavior data tracking sheets and verbal input from the team members. A written report is provided to the individual receiving services, the individual's parent or guardian, BDDS service coordinator, case manager and applicable service providers. The report covers the prior quarter progress on the behavior support plan including targeted behaviors and any need for an amendment to the plan.

The state is committed to assuring the use of behavior modifying medication as a last resort, requiring the individual's support team to be in agreement with the use of medication, and have the approval of the Human Rights Committee prior to implementation. Additional safeguards implemented when a psychoactive medication is administered on a PRN basis include:
(1) The behavioral support plan must include a hierarchy for obtaining administrative approval to administer the PRN medication, and an individualized protocol identifying the circumstances and conditions in which the PRN medication can be administered.
(2) The behavioral support plan must include a plan of desensitization addressing the situations that precipitate use of PRNs, such as medical visits and other situations that occur on a regular basis. The plan shall also include methods for staff to monitor and document the results of the desensitization process. (3) Monitoring and documentation of PRN administration must include an analysis of the effectiveness of each incident of administration, as well as a description of events leading up to the PRN administration, including any desensitization methods and their results. Documentation must detail the approval process, the date, time, and dosage of administration, and include a description of the individual's behavior after the administration, including any side effects or interactions with other medications. 4) The Individual Support Team must analyze and evaluate the effectiveness of PRN medication administration in eliminating targeted behaviors or symptoms, and address possible relationships between behavioral and medical issues. The Individual Support Team must ensure that treatment is provided in the least restrictive manner possible and that desensitization methods have been utilized and documented per the behavioral support plan.

In an emergency, chemical restraint, physical restraint, or removal of an individual from the individual's environment may be used without the necessity of a behavioral support plan, but only to prevent harm to the individual or others. The individual's support team is then required to meet not later than five working days after the emergency chemical restraint, physical restraint, or removal of an individual from the environment in order to:
(1) Review the circumstances of the emergency chemical restraint, physical restraint, or removal of an individual;
(2) determine the need for a functional analysis, behavioral support plan or both, and to document recommendations.
If a provider of behavioral support services is not a member of the individual's support team, a provider of behavioral support services must be added to the individual's support team.

The State has established through IAC 460-6-9-3, "Prohibiting Violations of Individual Rights", provider standards prohibiting abuse, neglect, exploitation, or mistreatment of an individual, or violation an individual's rights. "Seclusion by placing an individual alone in a room or other area from which exit is prevented" is specifically prohibited. Also prohibited are practices which deny an individual any of the following without a physicians order: Sleep, shelter, food, drink, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and

how such oversight is conducted and its frequency:

The Bureau of Quality Improvement Services (BQIS), the Bureau of Developmental Disabilities, and the Office of Medicaid Policy and Planning are responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed. Oversight of the use of restraints at the individual level occurs through the Individual Support Team and the case management functions as contracted to the Indiana Professional Management Group (IPMG). Unauthorized use of restraint is monitored through the incident reporting process, the complaint process, and the case management function, specifically through the required 90 day review. Additionally, the requirements of the three survey types; Agency, Residential and Vocational, conducted by the Bureau of Quality Improvement Services address behavioral support services to assure that appropriate plans are in place and implemented correctly. Agency surveys are conducted every three years. Requirements for routine medical care and monitoring provide another safeguard to detect unauthorized or inappropriately administered restraint.

Data gathered through incident reporting, complaints, surveys, and mortality review is compiled by the Bureau of Quality Improvement Services and reviewed by local risk management committees (monthly), the State Risk Management Committee (bi-monthly) and the Quality Improvement Executive Committee (monthly). Remedial action may be implemented at any of these levels, or through the DDRS Sanctions committee.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State allows the use of restrictive interventions when used in conjunction with a Behavioral Support Plan, or in an emergency situation only to prevent harm to the individual or others. Behavior support standards require that behavior plans employ non-aversive methods to replace maladaptive behaviors with functional and useful behaviors.

460 IAC 6-18-2, "Behavioral Support Plans", allows behavioral support plans which utilize restrictive interventions when the plan contains: (1) A functional analysis of the targeted behavior for which a highly restrictive procedure is designed; (2) documentation that the risks of the targeted behavior have been weighed against the risk of the highly restrictive procedure; (3) documentation that systematic efforts to replace the targeted behavior with an adaptive skill were used and found to be not effective; (4) documentation that the individual, the individual's support team and the applicable human rights committee agree that the use of the highly restrictive method is required to prevent significant harm to the individual or others; (5) informed consent from the individual or the individual's legal representative; (6) documentation that the behavioral support plan is reviewed regularly by the

individual's support team. The individual's support team participates in quarterly reviews with the behavioral support staff. The team reviews provider monthly reports, behavior data tracking sheets and verbal input from the team members. A written report is provided to the individual receiving services, the individual's parent or guardian, BDDS service coordinator, case manager and applicable service providers. The report covers the prior quarter progress on the behavior support plan including targeted behaviors and any need for an amendment to the plan.

The State has established through IAC 460-6-9-3, "Prohibiting Violations of Individual Rights", provider standards prohibiting abuse, neglect, exploitation, or mistreatment of an individual, or violation an individual's rights. Abuse is defined under 460 IAC 6-3-2, "Abuse", which includes "Unnecessary physical or chemical restraints or isolation". "Seclusion" by placing an individual alone in a room or other area from which exit is prevented is specifically prohibited from use under the rule. Also prohibited are practices which deny an individual any of the following without a physicians order: Sleep, shelter, food, drink, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Bureau of Quality Improvement Services (BQIS), the Bureau of Developmental Disabilities, and the Office of Medicaid Policy and Planning are responsible for overseeing the use of restrictive interventions and ensuring that State safeguards concerning their use are followed. Oversight of the use of restrictive interventions at the individual level occurs through the Individual Support Team and the case management function as contracted to IPMG. Unauthorized use of restrictive interventions and violations of rights is monitored through the incident reporting process, the complaint process, and the case management function, specifically through the required 90 day review. Additionally, the three survey types (Agency, Residential and Vocational) conducted pursuant to the BQIS Requirements address behavioral support services to assure that appropriate plans are in place and implemented correctly. Agency surveys are conducted every three years.

Data gathered through incident reporting, complaints, surveys, and mortality review is compiled by the BQIS and reviewed by local risk management committees (monthly), the State Risk Management Committee (bi-monthly) and the Quality Improvement Executive Committee (monthly). Remedial action may be implemented at any of these levels, or through the DDRS Sanctions committee.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

As participants in the Autism Waiver program are served in a variety of settings, the individual or organization identified in the Individualized Support Plan is responsible for the coordination of health care for the individual. 460 IAC 6-25-2, "Coordination of Health Care", includes annual physical, dental and vision examinations ordered by the physician, routine examinations and screening and referrals to specialists. 460 IAC 6-25-3, "Documentation of Health Care Services Received by an Individual", addresses

the need for providers to maintain the dates of health and medical services, a description of those services and the need for an organized system for medication administration. The system for medication administration must include a documentation system, a system for communication among all providers that administer medication and the monitoring of medication side effects. All providers are to have a health-related incident management system to provide an internal review process for any health related reportable incident – of which one is medication errors. The Case Management 90-Day Check List specifically addresses compliance with medication monitoring systems protocols. The incident reporting and complaint processes provide an additional monitoring resource.

When behavior modifying medications are used, the state mandates the individual's support team to be in agreement with the use of medication and have the approval of the Human Rights Committee prior to implementation. Additional safeguards implemented when a psychoactive medication is administered on a pro re nata (PRN "as needed") basis include:

1) The behavioral support plan must include a hierarchy for obtaining administrative approval to administer the PRN medication and an individualized protocol identifying the circumstances and conditions in which the PRN medication can be administered.

2) The behavioral support plan must include a plan of desensitization addressing the situations that precipitate use of PRNs, such as medical visits and other situations that occur on a regular basis. The plan shall also include methods for staff to monitor and document of the results of the desensitization process.

3) Monitoring and documentation of PRN administration must include an analysis of the effectiveness of each incident of administration as well as a description of events leading up to the PRN administration, including any desensitization methods and their results. Documentation must detail the approval process, the date, time, and dosage of administration and include a description of the individual's behavior after the administration, including any side effects or interactions with other medications.

4) The Individual Support Team must analyze and evaluate the effectiveness of PRN medication administration in eliminating targeted behaviors or symptoms and address possible relationships between behavioral and medical issues. The Individual Support Team must ensure that treatment is provided in the least restrictive manner possible and that desensitization methods have been utilized and documented per the behavioral support plan.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Through IAC 6-25-4, "Organized System for Medication Administration Required", the State requires providers have an organized system for medication administration for each participant receiving medications. The provider shall document the system in writing and distribute the document to all providers administering medication to the individual. The documentation shall be placed in the individual's file maintained by all providers administering medication to the individual.

This required system shall contain at least the following elements:

- Identification and description of each medication required for the individual;
- Documentation that the individual's medication is administered only by trained and authorized personnel unless the individual is capable of self-administration of medication as provided for in the individual's ISP;
- Documentation of the administration of medication, including administration of medication from original labeled prescription containers; the name of medication administered; the amount of medication administered; the date and time of administration; and the initials of the person administering the medication.
- The system must also include procedures for the destruction of unused medication;
- Documentation of medication administration errors;
- A system for the prevention or minimization of medication administration errors.
- When indicated as necessary by an individual's ISP, procedures for the storage of medication;
- Documentation of an individual's refusal to take medication;
- A system for communication among all providers that administer medication to an individual.
- All providers administering medication to the individual shall implement and comply with the organized system of medication administration designed by the provider.

BQIS, BDDS and OMPP are all responsible for monitoring and oversight of medication management practices and conduct analysis of medication errors and potentially harmful practices as discovered through incident reporting, the BQIS survey process, mortality review, the complaint process, and anecdotal

information presented through the risk management committee framework. Data is analyzed at the individual level, the provider level, the BDDS district level, and the state level. The Sanctions Committee acts to implement corrective measures by requiring plans of correction, and can implement disciplinary measures up to and including provider de-certification.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

460 IAC 6-14-4, "Training", requires that all staff be trained in medication administration. The state has an approved curriculum available for providers to use. 460-IAC 6-25-3, "Documentation of Health Care Services Received by an Individual", addresses the state's rules for medication administration and also includes the need for providers to maintain the dates of health and medical services, a description of those services and the need for an organized system for medication administration. The system for medication administration must include a documentation system, a system for communication among all providers that administer medication and the monitoring of medication side effects. All providers are to have a health-related incident management system to provide an internal review process for any health related reportable incident – of which one is medication errors (IAC 6-25-9, "Health Related Incident Management").

Under IAC 6-10-10, "Quality Assurance and Quality Improvement System", providers administering medications are required to have a quality assurance and quality improvement process to analyze medication errors, develop recommendations to reduce the risk of future errors, and review recommendations to assess for effectiveness.

Incident reporting policies require medication errors to be reported to BQIS as addressed under IAC 6-9-5, "Incident Reporting".

iii. Medication Error Reporting. *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  Medication errors must be reported to the Bureau of Quality Improvement Services through the incident reporting process under IAC 6-9-5, "Incident Reporting" and detailed within Appendix G-1-a of this application.

  (b) Specify the types of medication errors that providers are required to *record:*

  The types of medication errors required to be recorded are:

1) Wrong medication given that places an individual's health and welfare in jeopardy as determined by the personal physician.
2) Wrong dose given that places the individual's health and welfare in jeopardy as determined by the personal physician.
3) Missed medication that places the individual's health and welfare in jeopardy as determined by the personal physician.
4) Medication given outside the prescribed administrative window that jeopardizes an individual's health and welfare as determined by the personal physician.

(c) Specify the types of medication errors that providers must *report* to the State:

The types of medication errors required to be reported through the incident reporting process under IAC 6-9-5, "Incident Reporting", are:

1) Wrong medication given that places an individual's health and welfare in jeopardy as determined by the personal physician.
2) Wrong dose given that places the individual's health and welfare in jeopardy as determined by the personal physician.
3) Missed medication that places the individual's health and welfare in jeopardy as determined by the personal physician. (Refusal to take medications does not require filing of an incident report but should be followed up by medical personnel and the interdisciplinary team to ensure that the health and welfare of the individual is safeguarded. This information should also be documented in the individual's record)
d) Medication given outside the prescribed administrative window that jeopardizes an individual's health and welfare as determined by the personal physician.

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Data gathered through incident reporting, complaints, surveys, and mortality review is compiled by the Bureau of Quality Improvement Services and reviewed by local risk management committees (monthly), the State Risk Management Committee (bi-monthly) and the Quality Improvement Executive Committee (monthly). Remedial action may be implemented at any of these levels, or through the DDRS Sanctions Committee.

Appendix H: Quality Management Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to

measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and
- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Appendix H: Quality Management Strategy (2 of 2)

Attachment #1

The Quality Management Strategy for the waiver is:
H.1.a Level of Care

As described in Appendix B-6-d, when the Bureau of Developmental Disabilities Services (BDDS) receives an application for services, the BDDS Service Coordinator conducts an intake process to establish eligibility for developmental disability services, and waiver level of care screening if the individual indicates a desire to receive waiver services.

As described in B-6-f, level of care is redetermined on an annual basis by the waiver Case Manager. Indiana Professional Management Group (IPMG) is the centralized case management organization contracted by the Indiana Family and Social Services Administration (FSSA). IPMG ensures the processes in the current waiver document are being consistently applied to level of care redeterminations. The BDDS Case Management Liaison conducts quality assurance audits of IPMG processes on an annual basis to ensure IPMG is meeting the terms of its contract. In addition, the Bureau of Quality Improvement Services (BQIS) monitors and takes actions to address inappropriate level of care decisions.

BQIS issued a Request for Services (RFS) for a vendor to conduct quality assurance audits of initial level of care determinations and service plans and annual level of care redeterminations and service plans on at least 5% of participants annually. BQIS awarded the contract to a vendor with an estimated start date in early 2008. The vendor will monitor level of care and will work with the state in addressing inappropriate level of care decisions. The vendor will review the information provided by the applicant or participant in response to questions covered by the DDP and will readminister the DDP to arrive at an LOC. If appropriate, the vendor will visit with the applicant or participant and his/her advocate(s) to review collateral information. If the vendor arrives at a different determination than either the BDDS Service Coordinator or the IPMG Waiver Case Manager, documentation of both determinations will be reviewed by DDRS management. Data will be collected regarding LOC determinations and the BQIS Director will be provided monthly reports that will be reviewed by the Quality Improvement Executive Council (QIEC).

The QIEC serves as the strategic planning and action approval body for quality assurance and improvement direction and activities. The QIEC is comprised of the executive management of the Division of Disability and Rehabilitation Services, the Bureau of Developmental Disabilities Services, the Indiana Division of Aging, the Bureau of Quality Improvement Services, and the Office of Medicaid and Policy Planning. Patterns of inappropriate decisions by a service coordinator or case manager will be identified and addressed with the determiner's supervisor. If the data shows a system issue resulting in inappropriate decision, the matter will referred to the BDDS Case Management Liaison or BDDS Director of Client Services to identify, address and monitor the training provided to service coordinators and case managers.

H.1.b Service Plan

The Division of Disability and Rehabilitative Services (DDRS) has delegated ensuring service plan development is done in accordance with BDDS policies and procedures to IPMG. IPMG extensively trains its staff on the requirements of service plans and has in place a monitoring system that identifies inadequacies in the service plan before implementation. Inadequacies are addressed and the service plan is amended. Service plans are updated annually and as a participant's needs change. IPMG has a vigorous automatic tracking system that alerts the case manager and IPMG management of annual service plan revision dates. In addition, DDRS tracks service plan updates through its INsite database, random checks by BDDS personnel, and BQIS agency and residential surveys. Quality of service plans will be monitored by the new BQIS vendor starting in the 2nd quarter of 2008. The vendor will collect data regarding service plans and will provide the BQIS Director monthly reports. Deficiencies in service plan development will be identified as author specific or systemic. Specific issues are referred to the BDDS Case Management Liaison to identify, address and monitor in bimonthly meetings with IPMG management. Systemic issues will be reviewed by QIEC to determine if changes to BDDS policies and procedures are warranted.

Additionally, IPMG ensures services are delivered to the participant in accordance with the service plan. Participants are ensured choice in services, case managers and providers. Applicants may also choose a supervised group living home with ICF/MR accreditation. BDDS monitors services delivered to participants through home visits, calls and team meetings. BQIS performs provider agency surveys and residential surveys to ensure that services provided are in compliance with BDDS policies and rules and the individual's service plan.

Case managers work with providers to identify areas for improvement in delivering services to the participant. Continual inability to provide appropriate services are referred to BQIS for investigation or the Sanctions Committee to review and recommend technical assistance, training or sanctions. DDRS monitors IPMG's performance through the contract between the parties and the BDDS Case Management Liaison's quality assurance audits. Deficiencies or citations in the quality assurance audits are discussed with IPMG management and remediation plans are initiated. Continued non-compliance by IPMG may result in referral to DDRS Executive Management to review available contractual and legal remedies.

H.1.c: Qualified Providers

DDRS has an extensive provider approval process which providers must go through before they are allowed to provide services. Interested organizations must go through an informational training process before being given an application packet. The applicant organization's application materials are reviewed thoroughly by personnel with extensive experience in the delivery of services. Decisions regarding approval of providers are made carefully and in compliance with DDRS's rules and regulations as approved by the Office of Medicaid Policy and Planning (OMPP). DDRS has identified improvements to the provider approval process which will be implemented by December 2008. Identified changes include a more vigorous training protocol before a provider can begin providing services and a review by BQIS within ninety (90) days of beginning services. The new BQIS vendor will identify improvements in the delivery of services by the new provider and either provide needed technical assistance or refer the provider to Indiana Outreach Services or another qualified organization for assistance. The new BQIS vendor will monitor the implementation of

the recommended improvements, compile data and provide periodic reports to the BQIS Director. The BQIS Director, DDRS provider relations and the QIEC will review the data to identify, address and monitor provider specific and systemic needs. Training, bulletins and policies or procedures will be developed in response to the findings, if appropriate.

DDRS uses compliance surveys to verify provider compliance with Indiana law governing the provision of services to individuals with developmental disabilities. Approved providers undergo a compliance survey within 90 days of approval and once every three years thereafter. DDRS anticipates offering deemed status to providers accredited by approved accreditation organizations upon the promulgation of the revision of the Supported Living Regulations found at 460 IAC 6-1, et. seq. Promulgation is anticipated before year end 2008 but the timeline is dependent upon other State agencies involved in the promulgation process. DDRS is negotiating with prominent accreditation organizations in the developmental disability field to ensure that the accreditation criteria applied to Indiana approved providers cover all provisions of Indiana law. Approved providers that are accredited by a DDRS recognized accreditation organization will be exempt from the administrative portion of the BQIS compliance survey. BQIS will continue to survey providers related to the provision of services, especially those areas directly affecting the health and welfare of a participant. DDRS does not allow non –approved providers to provide reimbursable services under the waiver. Therefore, non-approved providers can not be enrolled as Medicaid waiver providers or receive reimbursement through Indiana's Medicaid Management Information System (MMIS).

The new BQIS vendor will conduct the compliance surveys described above beginning in early 2008. At the conclusion of a compliance survey, the surveyor(s) conducts an exit interview with the provider to review strengths and weaknesses of the provider and collaborate on a corrective action plan with agreed upon deadlines for implementation. The surveyors may recommend technical assistance, training or information from the Indiana Outreach Services Team or other knowledgeable expert. In addition, remediation plans that are not complete within 90 days of the exit meeting are referred to the BQIS Director to address with the provider directly. The BQIS Director refers noncompliant providers to the Sanctions Committee for review and possible sanctions. Information collected during compliance surveys is collected in a state approved database and monthly reports on findings and status of remediation plans are provided to the BQIS Director. The Risk Management Committee and the QIEC review the data to identify participant-specific, provider-specific or systemic issues. The Risk Management Committee and/or the QIEC will identify the appropriate method to address the issue including developing information sheets, training programs, proposed protocols, bulletins, policies and/or procedures. The BQIS Director, Risk Management Committee and the QIEC will monitor the implementation of the measures recommended.

H.1.d: Health and Welfare

DDRS conducts medical monitoring routinely through case management, BDDS visits, BQIS surveys and incident reports in compliance with 460 IAC Article 6, "Supported Living Regulations". Case managers complete 90 day checklists for each participant after meeting with the participant's Individualized Support Team. The checklist includes a review of the medical status of the participant. Incident reports are reviewed and coded by BQIS staff and follow-up is required by the case manager and/or provider. In addition, incident reports that are coded "sentinel" as defined in Appendix G-1-c are reviewed by BQIS staff and are referred to the Indiana Outreach Services team for training or technical assistance as deemed appropriate. In addition, as part of the compliance surveys discussed in H.1.c above, a valid random sample of participants receiving services from the approved provider are visited and specific health and welfare criteria are reviewed. If situations are identified where a participant is in immediate need of supports to ensure health and welfare, the surveyor contacts emergency services, Adult Protective Services, Child Protective Services (within the Division of Children's Services) and/or law enforcement. In addition, the surveyors may refer the participant for additional supports through Indiana Outreach Services or Crisis Assistance. Data is collected and analyzed followed by monitoring of identified issues as described in H.1.c above.

The new BQIS vendor is responsible for undertaking a review of the current incident reporting system during 2008 to identify recommended improvements. The contract requires that the vendor use the CMS Quality Framework as the basis for its review. The recommendations will be reviewed and analyzed by the BQIS Director and DDRS Executive Management and agreed upon improvements will be implemented in a reasonable timeframe to be determined by the magnitude of the required changes.

The BQIS Director of Investigations is requesting approval of new investigator positions to continuously monitor the health and welfare of waiver participants and will, on an ongoing basis, identify, address, and seek to prevent abuse, neglect and exploitation. The expected goals and outcomes include identifying, addressing and seeking to prevent abuse, neglect and exploitation, by monitoring waiver participants on an ongoing basis.

H.1.e: Administrative Authority

The State Medicaid Agency, OMPP, is responsible for the oversight of the administration of the HCBS waivers, including the eligibility determination process. DDRS and OMPP have a Memorandum of Understanding (MOU) that delineates each agency's responsibilities for the waiver program. This MOU is being reviewed as OMPP is revising its monitoring plan to require specific evidence-based reports as part of the deliverables.

The MOU includes the following responsibilities:
• Approval and enrollment of all providers of waiver services.
• Oversight of waiver activity, including case management, level of care (LOC) determinations, plan of care reviews, identification of trends and outcomes, and initiating action to achieve desired outcomes.
• OMPP shall retain final authority for approval of level of care and plans of care, review and approval of all waiver manuals, bulletins and communications regarding waiver policy and quality assurance/quality improvement plans prior to implementation or release to providers, participants, families or any other entity.

H.1.f: Financial Accountability

The approved service plan is entered into the State's electronic information management system (INsite) which is linked to Indiana's MMIS claim payment system. The MMIS system provides edits that can suspend or deny HCBS waiver claims when:
• Claims are for an individual not "coded" in the system as an approved HCBS waiver participant in the system.
• Claims are for service provision by agencies, companies, or individuals who are not enrolled in a Medicaid waiver program,
• Claims are for services or amounts of services (units or dollars) that are not included in the service plan or exceed the approved Plan of Care/Cost Comparison Budget (POC-CCB).

H2, H3 and H4

BQIS is the entity responsible for ensuring that waiver assurances are met. DDRS management has moved certain programs to BQIS to ensure that quality measures are consumer-focused. Crisis assistance and outreach services are now part of BQIS. Compliance surveys, satisfaction assurance, level of care and plan of care quality audits, sanctions, mortality review, complaints and investigations remain functions of BQIS.

BQIS assures quality through technical assistance to participants, families and providers. BQIS awarded a contract to a vendor to develop, during the first waiver year, a new compliance and satisfaction survey tool that uses the CMS HCBS quality framework as its basis. The vendor is responsible for financial audits of participant funds, compliance and satisfaction surveys, mortality review and incident reporting. Outsourcing these functions will assist the State with access to highly qualified professional staff to perform these duties, ultimately ensuring improved quality outcomes for the participants.

The quality reporting structure through BQIS is centralized through the Quality Improvement Executive Council ("QIEC"). The QIEC meets on a monthly basis to review reports and recommendations of its subcommittees and programs (Risk Management, Sanctions, Mortality Review, Incident Reporting, Crisis Assistance and Outreach Services). On a quarterly basis, the QIEC invites members of the community, including self-advocates, family members, providers and other interested parties, to participate in the quality assurance and improvement activities. The QIEC analyzes information provided by the reporting committees and the BQIS vendor, identifies action necessary to ensure waiver assurances are being met and that participants are free from abuse, neglect and exploitation.

The QIEC requests "drill down" into presented data to better understand the root cause of trends, instructs committees to further investigate issues, requests the development of training, information sheets, bulletins, policies and procedures, focus groups, task forces and recommends technical assistance for specific participants and providers and other actions. Monitoring of the actions between meetings is implemented by the BQIS Director, or designee, as directed by the QIEC.

Additionally, the State operates quality assurance programs for individuals served through BDDS. BQIS works cooperatively with BDDS, DDRS Initiatives Group, Outreach Services and the provider community to implement the following quality improvement programs:

RISK MANAGEMENT – The Indiana risk management structure is a tiered system that encompasses oversight at the local, district (eight BDDS districts) and state levels. Each local risk management committee focuses on high-risk issues at the consumer level. They review incidents and issues affecting both the DD service population and a select group of consumers with more complex needs. These committees review specific data as well as anecdotal

information to assure best practices at the individual level. The local committees also review district and provider trends and make recommendations to a State Risk Management Committee. The State Committee, comprised of personnel from BDDS, BQIS, DDRS, Outreach Services, Crisis Management, IPMG and OMPP, reviews local recommendations and statewide data, including survey and mortality review findings, and makes recommendations to a variety of sources, including the local committees, the QIEC, BDDS, BQIS and Outreach services.

BQIS has initiated a risk management process in all of the BDDS districts within the state. Upon initiating the risk management process in each of the districts, introduction meetings have been held with the BDDS Field Staff in an effort to educate the Service Coordinators and District Managers about the Risk Management Process. The Districts have monthly risk management meetings. Initially, District Staff are oriented to the format of the meetings and the Subcommittee meetings. Providers are subsequently introduced to the State Risk Management Process.

The District Risk Management Committee is comprised of Outreach Staff, BDDS and BQIS Field Staff and a representative from IPMG. The District Risk Management Committee analyzes information to determine if individuals are at heightened risk due to medical or behavioral issues. The identified individuals, as well as any individual who has transitioned out of an institution in the prior two years, are added to a "high risk" list. These individuals are tracked by the District Risk Management Committee that monitors the individual's risk issues. For each individual on the high risk list, a risk assessment packet is sent to the individual's community support team. Upon completion of the risk assessment tool, Outreach staff will review and identify risk issues, suggest protocols and additional assessment tools to assist the individual's community support team in addressing the risk issues. Individual situations, including the implementation of the protocols, are discussed in depth during Subcommittee Meetings of the District Risk Management Committees in an effort to identify solutions and next steps for the participant's community support team to try to mitigated the participant's risk issue(s). Individual's names are added to, and removed from, the high risk list during subcommittee meetings. District Risk Management Committees provide recommendations to the State Risk Management Committee on systemic issues which need to be addressed.

The State Risk Management Committee addresses issues by forming task groups to further study identified trends, delve deeper into root causes and develop targeted recommendations to the QIEC for suggested action.

CONSUMER SATISFACTION SURVEYS - BQIS utilizes surveys to monitor the level of satisfaction of individuals participating in Medicaid HCBS Waiver Programs and receiving other services throughout the State. The surveys are conducted through the administration of the National Core Indicators Project (NCIP). The NCIP includes a national data collection agency that collects and analyzes Indiana's data in comparison to other participating states. BQIS Quality Monitors conduct interviews with service recipients and their families, guardians or advocates. Via valid random sample, individuals served under the Autism Waiver are invited to participate in the voluntary survey. BQIS interviews at least 15% of people served by BDDS annually. Data collected during the interviews are submitted to the national database described above. In addition, BQIS analyzes the data collected annually and submits the report to the QIEC for review and to take action. The new BQIS vendor is adopting a new nationally recognized satisfaction tool that will be implemented by the end of the third quarter 2008.

PROVIDER SURVEYS – The provider compliance survey process is discussed in detail in Appendix H.1.c.

COMPLAINT RESOLUTION/INCIDENT REPORTING – BQIS receives complaints related to services and providers through any available communication source. A Qualified Mental Retardation Professional (QMRP) level staff member investigates complaints to assess whether the complaints are substantiated. The staff then imposes a corrective action plan, refers to the Sanctions Committee, a BQIS investigator or law enforcement for further investigation or a combination of any and all of the preceding steps. Complaints and Investigation data is entered into the Complaint Incident Reporting System (CIRS) database. Annual reports are generated and included in the annual Risk Management report and are reviewed by the QIEC. Systemic issues are addressed at the QIEC level. Issues involving the health or welfare of a participant are addressed immediately by BDDS, BQIS, IPMG, Outreach, Crisis Management or a combination of any or all of the above entities. BQIS is ultimately responsible to ensure recommendations are implemented.

Incident reporting is the cornerstone of monitoring of consumer supports for BDDS. The BQIS Assistant Director of Data Management analyzes incident reporting data monthly and shares this data with the QIEC for review, analysis and action. The QIEC delves into the data and requests certain "drill down" data and different reports to determine what the data is actually telling us about participants and providers. On a quarterly and annual basis, the BDDS Assistant Director prepares comprehensive reports comparing incident reporting data across categories of services. These reports are shared with the QIEC and community members. Actions of the QIEC include referrals of providers for sanctions or technical assistance, commissioning information sheets, training materials, protocols, bulletins, policies and/or procedures. As described earlier in this Appendix, the new BQIS vendor is undertaking a review of the incident

reporting system.

MORTALITY REVIEW - The Mortality Review Committee (MRC) reviews information related to the death of persons with developmental disabilities receiving services through DDRS and persons receiving certain services from the Indiana Division of Aging (IDA). The MRC is made up of doctors, nurses, and staff from BDDS, IDA, OMPP, advocates and family members. Reports are generated and the information is reviewed to identify trends, direct training needs and to develop recommendations which are forwarded to the QIEC. As appropriate, the MRC also makes recommendations to BQIS and the State Department of Health for further investigation. The MRC meets monthly, discussing potential systemic issues at each meeting. Systemic issues and recommended training needs are submitted quarterly to the Director of BQIS, who then reviews the recommendations with the QIEC.

The activities described in Appendix H under items H2, H3 and H4 guide the development of recommendations, policy updates, informational bulletins and training opportunities that are disseminated (electronically and on the website) to waiver service providers and case managers for implementation and further dissemination, as applicable, to waiver participants.

H5

The BQIS Director continually reviews quality assurance and improvement measures for waiver recipients. At least annually, the Director of BQIS, along with designated staff, will review the Quality Management Strategy (QMS) and confirm information contained in the QMS or update the information as necessary, updating the QMS as needed. The (QMS) will also be reevaluated prior to the submission of the waiver renewal application.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In order to ensure the integrity of payments that have been made for waiver services, the agency will assure financial accountability for funds expended for home and community based services, provide for an independent audit of its waiver program and it will maintain and make available to the U.S. Department of Health and Human Services, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. The State of Indiana conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98 502.

The Indiana State Board of Accounts is responsible for the state's financial audit program. As an agency of the executive branch, the State Board of Accounts audits all governmental units within the state, including cities, towns, utilities, schools, counties, license branches, state agencies, hospitals, libraries, townships, and state colleges and universities. The Indiana State Board of Accounts, as part of the audit process, renders opinions on the fairness of presentation of the various units financial statements in accordance with the same professional auditing standards required of all independent audit organization. Investigatory audits are performed to reveal fraud or noncompliance with local, stated and federal statutes. (IC 5-11). The Indiana State Board of Accounts audits the Division of Aging contracts to ensure that provider payments are made in accordance with the contractual obligations.

As noted within Appendix A, Item 3.B. of this application, waiver auditing functions will be incorporated into the Surveillance Utilization Review (SUR) functions of a contract negotiated between the Medicaid agency and selected contractor. Implementation is expected to occur during 2008, the first year of the Autism Waiver Renewal.

The selected contractor will construct an audit process that utilizes data mining, research, identification of outliers, problem billing patterns, aberrant providers, and providers referred by the state. The vendor will conduct home visits to verify that services billed are authorized in the plan of care, delivered, and are meeting the needs of the member. Auditors will verify the participant's eligibility for waiver services, and will build provider specific and aggregate data to determine common problems, determine benchmarks, and provide individual provider data that can

be compared against aggregated data. Trending will identify areas of educational need, as well as validate effectiveness of education. The OMPP will oversee the contractor's monthly reports of reviews.

The Contractor will ensure that the plan of care will contain, at minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service. Additionally, it is expected that the Medicaid agency [known as the Office of Medicaid Policy and Planning (OMPP)] staff will periodically accompany the contractor on-site, to observe the waiver services.

From Appendix A, Item 5, the Medicaid agency will be responsible for oversight of waiver audit functions performed by the selected Surveillance and Utilization Review (SUR) contractor during 2008, the first year of the Autism Waiver Renewal.

From Appendix A, Item 6, in order to assure that the contracting entity selected to perform waiver auditing functions under the Surveillance Utilization Review (SUR) contract negotiated by OMPP is satisfying conditions of the contract, OMPP will exercise oversight and monitoring of the deliverables stipulated within that contract. Reporting requirements will be determined as agreed upon within the fully executed contract, which is expected to be implemented during the year 2008, the first year of the Autism Waiver Renewal.

The provider in accordance must maintain for the purposes of the service agreement an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP), as interpreted by the Division of Developmental Disability and Rehabilitative Services (DDRS), and to any other accounting requirements which DDRS may require.

The DDRS or any other legally authorized governmental entity (or their agents) may at any time during the term of the service agreement and in accordance with Indiana Administrative Regulation conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this service agreement. Additionally, DDRS may at any time conduct audits for the purpose of assuring appropriate administration and delivery of services under the service agreement. As stated within the Appendix H heading "H2, H3 and H4", financial audits is among the areas of responsibility assigned to the selected vendor of certain Quality Improvement Services.

The provider must provide DDRS access at any time to all records, materials, and information including all audit reports with supporting documentation. Such access will be provided until the expiration of six years from the completion date of each respective fiscal year.

A non-profit contractor, if receiving $500,000 or more in federal funds for any and all federal funding sources must comply with the accounting and audit requirements of Federal Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" and the provisions of OMB Circular "A-122 Cost Principles for Non-Profit Institutions".

A for-profit provider must comply with the accounting and audit requirements in 45 CFR 72.26(d) and the cost principles and procedures for commercial organizations in 48 Subpart CFR 31.2 concerning the use of funds provided under this service agreement. Pursuant to 45 CFT 74.26(d), a "for-profit" organization may either have an audit conducted in accordance with the Federal Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" or the Governing Auditing Standards.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

PRIOR TO 2008: Statewide rates were computed for four new service/unit types implemented to replace a number

of other end-dated services. This service update was referred to as the "Annual Plan." The new services were: 1) Residential Habilitation and Supports – Daily (RHSA), 2) Day Services (DSRV), 3) Behavior Management – Basic (Behavioral Support Services); Monthly (BMGT), and 4) Behavior Management – Level 1 (Behavioral Support Services); Monthly (BMG1).

RATE COMPUTATIONS (General): Unique rates were computed for each individual waiver recipient, based on the dollars paid to providers for specific services rendered to that individual during State Fiscal Year 2005 (July 1, 2004 – June 30, 2005). The paid claim history was extracted from the Indiana's Medicaid Management Information System (MMIS)(Indiana AIM), and initially included all claims processed (paid or approved) as of August 30, 2005. Paid claim amounts were summed and rates determined by individual Medicaid RID number. This paid claim history included both positive and negative dollar amounts. Initial rate calculations were executed by an actuarial firm under contract to the State (Milliman), with subsequent rate determinations being made by the State's Medicaid Waiver Unit.

THE RHSA RATE WAS COMPUTED using the following methodology: This basic rate was composed of two distinct paid claim summary components.
1. Residential Services Component: The first component included the following service codes:

o RHS1 (T2017 U7) – Level 1 – Under 35 hours per week
o RHS2 (T2021 U7 TF) – Level 2 – QMRP for those receiving RHS1
o RHS3 (T2017 U7 TG) – Level 3 – Over 35 hours per week
o IAS (T2017 U7 U1) – Less than 30 hours per month

All paid claim history for each RID was summed to determine an annual rate and divided by the estimated number of days of service to establish the billing increment. That amount was reduced by the following percentage to produce the residential component for RHSA:

Base Daily Rate	Reduction	Recipients Affected	
$.01 – 161.99	0%	2,465	49%
$162.00 – 179.99	1 – 2%	339	7%
$180.00 – 197.99	2 – 3%	344	7%
$198.00 – 249.99	3 – 5%	902	18%
$250.00 – 299.99	6 – 7%	427	9%
$300.00 – 349.99	8 – 9%	299	6%
$350.00 – 449.99	9 – 10%	180	4%
$450.00 – above	0%	25	1%

2. Residential supports: This included the following service codes:
o HCC1 (T2022 U7 U1, T2022 U7 U2, T2022 U7 U3, T2022 U7 U4) – Health Care Coordination at 4 levels of support.
o TLV1 (T2004 U7 U1), TLV2 (T2004 U7 U2) – Transportation for those in 24 hour supported living settings.
o T1ST (T2004 U7 U3), T2ND (T2004 U7 U4) – Transportation for those in less than 24 hour settings with the service provided by the residential provider
o CHPI (T2021 U7) – Community Based Individual provided by the residential provider.
All paid claim history for each RID was summed to determine an annual rate, then divided by the estimated number of days of service to establish this component for RHSA. The resulting amounts for these two components were added together to produce the basic RHSA allotments for each individual served.
The DSRV rate was computed using the following methodology: The Day Services rate included various Community Habilitation and Participation services, vocational supports, and related transportation services. It was a summary of the paid claim history from the following service codes:
o CHPG (T2021 U7 HQ) – Community Based Group
o CHPR (T2021 U7 UA HQ) – Facility Based Group
o CHPF (T2021 U7 UA) – Facility Based Individual
o HPV (T2015 U7) – Pre-vocational services
o HSE (H2023 U7) – Supported Employment
o TD1 (T2004 U7 U6), TD2 (T2004 U7 U8) – Transportation provided by the Day Service provider
o CHPI (T2021 U7) – Community Based Individual for those that received this service from a provider other than their residential provider.

All paid claim history for each RID was summed to determine an annual rate then divided by the estimated number of days of service to establish the DSRV allotment for each individual served.

Note: CHP – Individual (CHPI) was computed separately so that it could be included with either RHSA or DRSV as noted above. It was the sum total of all paid claim amounts for SFY05 for the service code CHPI (T2021 U7), divided by the estimated number of days of service.
BMGT and BMG1 rate computation: Both behavioral support services directly correlate (one for one) with existing service codes and both use the same computation methodology. BMGT included all SFY05 paid claims for existing service code BMAN (H004 U7 U2), and BMG1 included all SFY05 paid claims for BMN1 (H004 U7 U1). The total annual paid claim amount was divided by 12 to produce a base monthly rate, and multiplied by .92 (8% reduction) to produce the final monthly rate for the BMGT and BMG1 services.

RHSA, DSRV, BMGT and BMG1 rates for individuals new to the waiver: These rates are established by comparing the individual and his/her circumstances to waiver recipients with similar needs.

Case Management (CM) Monthly Services: Based on the State's recognition of the average amount of CM service required to support a waiver recipient in a typical month, a flat monthly rate was assigned to each waiver for CM services.

CHANGES to the Rate Determination Methods are being phased in statewide through December 2009. During the first year of the Renewal (2008), DDRS is engaging in the design of standardized provider reimbursement rates. DDRS requires providers be reimbursed for actual services delivered, that the rate for each waiver service is discreet and "transparent", and that the rates treat all providers in a "fair and equitable" fashion.

RATE DEVELOPMENT TASKS AND TIMELINES: The provider reimbursement rate initiative involves the five key tasks described below.
1. Reimbursement Rate Methodology Review: DDRS is conducting a review of current provider expenditure/utilization data, reimbursement rate methodologies, assumptions/pricing incentives, budget forecasting/cost containment strategies, and risk management/risk reserve practices.
2. Rate Development: Based upon the fiscal and service utilization data, and the rate methodology review, DDRS is designing a reimbursement rate methodology and associated published fee schedule for pilot and implementation. This methodology / standard fee schedule identifies critical cost factors and relevant pricing benchmarks. Provider cost data is being obtained from the provider costs reports completed by each agency. Provider cost reports and audited financial statements are required from ALL PROVIDERS STATEWIDE. This fee schedule together with the Objective Assessment System for Individual Supports (OASIS) service utilization standards will serve as the basis for calibration of the Inventory for Client and Agency Planning (ICAP) to resource allocation levels. Draft reimbursement rates became available for testing July 2007.
3. Rate Shadowing: All providers in the Bureau of Developmental Disability Services (BDDS) District 4 were involved in "shadowing" of draft reimbursement rates. Providers compared reimbursement levels to draft rates as various methods of reimbursement invoicing were developed and tested. Based upon findings from the providers, reimbursement rates were adjusted and modified to address equity and consistency issues, but no agency received a reduction in revenue.
4. Rate Testing: Implementing the revised rate schedule; invoicing process; and reimbursement from January 2008 through June 2008 involves ONLY providers in BDDS DISTRICT 4. During the testing phase, additional rate adjustments and revisions are being made as needed as providers test the revised invoicing / billing system to ensure that payments are made in an accurate and timely fashion. Beginning in July 2008, the final standardized reimbursement rate schedule will be published in final edition. The evaluation will be based upon ease and relevance of use, containment of cost, and achievement of quality outcomes.
5. Rate Implementation: The rate implementation begins July 2008 on a BDDS District basis and is to be phased-in statewide over an eighteen month period. DDRS is incorporating various findings and decisions collected during the Initial Implementation phase to extend the rates to the remaining Districts. This implementation includes consumer and provider training, workshops, and technical assistance.
Application Item 6-I "Public Input" notes DDRS operates a 24-hour helpline and maintains an open door policy, welcoming public input regarding potential policy changes. The DDRS held statewide public meetings and forums throughout the development and implementation of the OASIS project while seeking input from waiver participants, families, providers and advocates, such as Arc of Indiana and INarf.
DESCRIPTION OF RATE STRUCTURE: DDRS is converting the provider reimbursement approach from a negotiated rate system to a standardized fee-for-service system for the HCBS waiver program.

The three major components to the DDRS Rate Initiative are:
1. Direct Care Staff Time as the Billable Unit: With the exception of adaptive equipment / environmental modifications and transportation, all provider reimbursement is based upon the amount of direct care staff time delivered to the consumer by the provider. In order to meet the conditions for payment, the consumer must be Medicaid eligible, enrolled, in attendance, and receive a HCBS service; and the direct care staff must be actively

employed and present to provide the HCBS service. In addition, the service provided must be consistent with the participant's individualized service plan.
2. Standardized Cost Centers: All provider reimbursement rates consist of the following four cost centers:
• Direct care Staff Compensation: The two primary job classes used from these compensation studies are Personal Support Workers (staff who perform at least 85% of the typical duties of a DD attendant with a high school degree and no special training) and Habilitation Workers (staff who perform at least 85% of the duties of a DD attendant with an Associate Arts degree or Certified Nursing Assistant, or special training).
• Employee-Related Expenses: These refer to the benefits package that is offered to all employees who are involved in the care and services provided to the person with disabilities and are divided into two groups. Discretionary costs are those associated with benefits provided at the discretion of the employer and are not mandated by local, state, or federal governments. Non-discretionary costs are those related to employment expenditures that are mandated by local, State, and Federal governments and are not optional to the employer.
• Program Supervision and Indirect Expenses: These expenditures are part of the operation of the setting in which residential habilitation occurs and related to the programs which occur within the setting, but are not directly tied to the direct care staff. They include program management and clinical staff costs as well as program operational expenses.
• General and Administrative Expenses: These costs are those associated with operating the organization's business and administration and are not directly related to the clients or the programs that serve the clients.
3. Other Factors: In addition to the standardized cost centers, geographical factors, economy-of-scale and holiday factors will also be applied.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All billings for waiver services flow through the State of Indiana's MMIS. MMIS receives most claims (billings) directly in a HIPAA-compliant electronic format. HIPAA-compliant paper claims are also accepted.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. Public agencies do not certify expenditures for waiver services.**
- ( ) **Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Non-State Public Agencies.**

Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) and b) As outlined under Appendix D-1-c and D-1-d, the service plan development process encompasses the use of reimbursable as well as non-paid services and supports, including natural supports when available. The Case Manager is responsible for incorporating into the participant's Individualized Support Plan (ISP), the entire array of services and supports necessary to meet the needs of the participant. However, the Plan of Care/Cost Comparison Budget (POC/CCB) associated with the Autism Waiver contains only those reimbursable services from the ISP that are available under the Autism Waiver.

The State Medicaid Waiver Unit approves an individual's (POC/CCB) within the State's case management application database (INsite), ensuring that only those services which are necessary and reimbursable under the Autism Waiver appear on the POC/CCB when prior authorization is sent to the state's MMIS. The INsite data system will not allow the addition of services beyond those services offered under the Autism Waiver. The INsite data system has been programmed to alert the Waiver Unit when a POC/CCB is being reviewed for a participant whose Medicaid eligibility status is not currently open within an acceptable category as was discussed under Appendix B-4-b. When the appropriate Medicaid eligibility status is in place, the Approval of the POC/CCB generates a Notice of Action (NOA) which is sent to each authorized provider of services on the Plan. The NOA identifies the individual service recipient, the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

INsite transmits a data package (typically each business night) containing all new or modified POC/CCB service and rate information to the Indiana MMIS. The POC/CCB data is utilized by the MMIS as the basis to create or modify Prior Authorizations for billing of services against Medicaid waiver participants.

Annual Plan services are billed only in daily, monthly, or once-per-POC/CCB units. The Prior Authorizations are set as a max rate per unit for each individual waiver participant that matches the approved daily, monthly or one-time unit rate approved for the individual. Because only one daily unit may be billed for each date of service, and only one monthly unit may be billed for each month of service, this prevents providers from being paid more than the amount approved for the participant for each unit.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made according the Prior Authorization remaining for the claimed unit(s) during the dates of service being claimed against. The MMIS also confirms that the waiver participant had the necessary Level of Care and Medicaid eligibility for all dates of service being claimed against.

c) Documentation and proof of actual service delivery tied to the billing by the provider agency will be reviewed during the look behind efforts of the Bureau of Quality Improvement Services detailed under Appendix H as well as by the contractor selected to fill the Surveillance Utilization Review (SUR) contract executed by the Office of Medicaid Policy and Planning and detailed under Appendix D-1-g.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- **No. The State does not make supplemental or enhanced payments for waiver services.**
- **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe:(a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

- **No. Public providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- **Yes. Public providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to Public Providers.

Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, how the State recoups the excess and

returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- **The amount paid to public providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services.**

Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):

- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no non-State level sources of funds for the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Revenues.**

Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source (s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

☐ **Other non-State Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:
  - [ ] **Provider taxes or fees**
  - [ ] **Provider donations**
  - [ ] **Federal funds (other than FFP)**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The State of Indiana excludes Medicaid payment for room and board for individuals under the waiver except for respite or in the case of a live-in caregiver. No room and board costs are figured into allowable provider expenses. There are provider guidelines for usual and customary fee, and the provider agreement states that a provider may only provide services for which the provider is certified. No provider, other than respite or in the case of a live-in caregiver, is certified to provide room and board. Waiver service providers are paid a fee for each type of direct service provided; no room and board costs are included in these fees.

Based on the method for establishing the fee for each waiver service, the State of Indiana assures that no room and board costs (other than respite or the costs of live-in caregivers) are paid through Medicaid. Indiana provider audit procedures also review provider billing and all allowable costs to further assure no room and board payments are made.

Federal Financial Participation (FFP) will not be claimed in expenditures for the cost of room and board, with the following exceptions:
• When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility)
• Meals furnished as part of a program of adult day services

• When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver.

With the exception of Respite Care, Residential Habilitation and Supports (under agency-based residential services) is the only service furnished in a residential setting other than the natural home of the individual (foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements).

NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

a) The State uses the following method to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.
• Room and board expenses of non-related, live-in caregivers are based on an estimate of the cost of food and housing in typical two and three bedroom apartments. The amount paid for live-in caregiver will be up to the federal benefit level under SSI for an individual living in the home of another, or actual expenses, whichever is the lesser amount

b) This service must be an approved service and included in the Plan of Care/Cost Comparison Budget (POC/CCB) in order to be reimbursed through the Medicaid MMIS.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total

computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	33615.05	5222.00	38837.05	86719.00	3799.00	90518.00	51680.95
2	34759.33	5536.00	40295.33	89754.00	4027.00	93781.00	53485.67
3	36125.80	5868.00	41993.80	92896.00	4269.00	97165.00	55171.20
4	37406.23	6220.00	43626.23	96147.00	4525.00	100672.00	57045.77
5	40054.92	6593.00	46647.92	99512.00	4797.00	104309.00	57661.08

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	430	430
Year 2	480	480
Year 3	530	530
Year 4 (renewal only)	580	580
Year 5 (renewal only)	600	600

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Phase-in/Phase-out charts were completed for each waiver year.

New slots were added gradually each year, spread evenly by month. Based on experience, the expected lapse rate for this population is approximately 0.1% per month, or one participant every 2 – 3 months.

50 slots were added during each of waiver years 1 through 4. During this time the average length of stay is relatively stable, creeping up gradually as the new entrants become a smaller percentage of overall waiver recipients. The average length of stay increases by 10 days in waiver year 5 because only 20 new slots are added.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The number of users of each service was taken from the CMS 372 for the period January 1, 2006 – December 31, 2006. Data from this period was adjusted to reflect expected changes in the total number of unduplicated participants during each waiver year. In addition, where a service was not used during 2006, it was assumed that one waiver recipient would use the service one time during Waiver Year 1 (January 1, 2008 – December 31, 2008).

The average units per user was similarly taken from the CMS 372 for the period January 1, 2006 – December 31, 2006. Expenditures for each service was divided by number of users and cost of the service. This was adjusted each waiver year for changes in the average length of stay on waiver. Where a service was not used during 2006, it was assumed that one waiver recipient would use the service one time during Waiver Year 1 (January 1, 2008 – December 31, 2008).

Average cost per unit: current rates during 2007 were used, and inflated at an annual rate of 3.5%.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is derived from the CMS 372 for the period January 1, 2006 – December 31, 2006. This factor was inflated at a rate of 6.0% each year.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is derived from the CMS 372 for the period January 1, 2006 – December 31, 2006. This factor was inflated at a rate of 3.5% each year.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is derived from the CMS 372 for the period January 1, 2006 – December 31, 2006. This factor was inflated at a rate of 6.0% each year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Adult Day Services
Day Services
Rent and Food for Unrelated Live-In Caregiver
Residential Habilitation and Support
Respite Care
Adult Foster Care
Behavioral Support Services/Crisis Assistance
Community Transition Services
Environmental Modifications
Family and Caregiver Training
Music Therapy
Occupational Therapy
Personal Emergency Response System
Physical Therapy
Psychological Therapy
Recreational Therapy
Specialized Medical Equipment and Supplies
Speech/Language Therapy

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**2796.36**
Adult Day Services	1/2 Day	1	84.00	33.29	**2796.36**	
Day Services Total:						**589662.00**
Day Services	Day	100	141.00	41.82	**589662.00**	
Rent and Food for Unrelated Live-In Caregiver Total:						**610.58**
Rent and Food for Unrelated Live-In Caregiver	Month	1	1.00	610.58	**610.58**	
Residential Habilitation and Support Total:						**12230602.86**
Residential Habilitation and Support	Day	399	373.00	82.18	**12230602.86**	
Respite Care Total:						**183978.08**
Respite Care	1/4 Hour	136	286.00	4.73	**183978.08**	
Adult Foster Care Total:						**226613.60**
Adult Foster Care	Month	8	10.00	2832.67	**226613.60**	
Behavioral Support Services/Crisis Assistance Total:						**990411.84**
Behavioral Support Services/Crisis Assistance	Month	288	11.00	312.63	**990411.84**	
Community Transition Services Total:						**1035.00**
Community Transition Services	Unit	1	1.00	1035.00	**1035.00**	
Environmental Modifications Total:						**20353.92**
Environmental Modifications	Unit	3	1.00	6784.64	**20353.92**	
Family and Caregiver Training Total:						**12420.00**
Family and Caregiver Training	Year	6	1.00	2070.00	**12420.00**	
Music Therapy Total:						**107868.51**
Music Therapy	1/4 Hour	57	163.00	11.61	**107868.51**	
Occupational Therapy Total:						**19.38**
Occupational Therapy	1/4 Hour	1	1.00	19.38	**19.38**	
Personal Emergency Response System Total:						**75.36**
Personal Emergency Response System	Each	1	2.00	37.68	**75.36**	
Physical Therapy Total:						**19.51**
Physical Therapy	1/4 Hour	1	1.00	19.51	**19.51**	

Psychological Therapy Total:						**17.34**
Psychological Therapy	1/4 Hour	1	1.00	17.34	**17.34**	
Recreational Therapy Total:						**46184.58**
Recreational Therapy	1/4 Hour	18	221.00	11.61	**46184.58**	
Specialized Medical Equipment and Supplies Total:						**5398.69**
Specialized Medical Equipment and Supplies	Each	1	1.00	5398.69	**5398.69**	
Speech/Language Therapy Total:						**36405.66**
Speech/Language Therapy	1/4 Hour	6	311.00	19.51	**36405.66**	

GRAND TOTAL:	**14454473.27**
Total Estimated Unduplicated Participants:	**430**
Factor D (Divide total by number of participants):	**33615.05**
Average Length of Stay on the Waiver:	345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**2893.80**
Adult Day Services	1/2 Day	1	84.00	34.45	**2893.80**	
Day Services Total:						**677531.79**
Day Services	Day	111	141.00	43.29	**677531.79**	
Rent and Food for Unrelated Live-In Caregiver Total:						**631.95**
Rent and Food for Unrelated Live-In Caregiver	Month	1	1.00	631.95	**631.95**	
Residential Habilitation and Support Total:						**14118684.10**
Residential Habilitation and Support	Day	445	373.00	85.06	**14118684.10**	
Respite Care Total:						**213012.80**
Respite Care	1/4 hour	152	286.00	4.90	**213012.80**	

Adult Foster Care Total:						**263862.90**
Adult Foster Care	Month	9	10.00	2931.81	**263862.90**	
Behavioral Support Services/Crisis Assistance Total:						**1142525.67**
Behavioral Support Services/Crisis Assistance	Month	321	11.00	323.57	**1142525.67**	
Community Transition Services Total:						**1071.23**
Community Transition Services	Unit	1	1.00	1071.23	**1071.23**	
Environmental Modifications Total:						**21066.30**
Environmental Modifications	Unit	3	1.00	7022.10	**21066.30**	
Family and Caregiver Training Total:						**14997.15**
Family and Caregiver Training	Year	7	1.00	2142.45	**14997.15**	
Music Therapy Total:						**125392.64**
Music Therapy	1/4 Hour	64	163.00	12.02	**125392.64**	
Occupational Therapy Total:						**20.05**
Occupational Therapy	1/4 Hour	1	1.00	20.05	**20.05**	
Personal Emergency Response System Total:						**78.00**
Personal Emergency Response System	Each	1	2.00	39.00	**78.00**	
Physical Therapy Total:						**20.19**
Physical Therapy	1/4 Hour	1	1.00	20.19	**20.19**	
Psychological Therapy Total:						**17.94**
Psychological Therapy	1/4 Hour	1	1.00	17.94	**17.94**	
Recreational Therapy Total:						**53128.40**
Recreational Therapy	1/4 Hour	20	221.00	12.02	**53128.40**	
Specialized Medical Equipment and Supplies Total:						**5587.65**
Specialized Medical Equipment and Supplies	Each	1	1.00	5587.65	**5587.65**	
Speech/Language Therapy Total:						**43953.63**
Speech/Language Therapy	1/4 Hour	7	311.00	20.19	**43953.63**	
				GRAND TOTAL:		**16684476.19**
				Total Estimated Unduplicated Participants:		**480**
				Factor D (Divide total by number of participants):		**34759.33**
				Average Length of Stay on the Waiver:		345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**5990.88**
Adult Day Services	1/2 Day	2	84.00	35.66	**5990.88**	
Day Services Total:						**782476.80**
Day Services	Day	123	142.00	44.80	**782476.80**	
Rent and Food for Unrelated Live-In Caregiver Total:						**654.07**
Rent and Food for Unrelated Live-In Caregiver	Month	1	1.00	654.07	**654.07**	
Residential Habilitation and Support Total:						**16198224.24**
Residential Habilitation and Support	Day	492	374.00	88.03	**16198224.24**	
Respite Care Total:						**244455.12**
Respite Care	1/4 Hour	168	287.00	5.07	**244455.12**	
Adult Foster Care Total:						**303443.00**
Adult Foster Care	Month	10	10.00	3034.43	**303443.00**	
Behavioral Support Services/Crisis Assistance Total:						**1304100.60**
Behavioral Support Services/Crisis Assistance	Month	354	11.00	334.90	**1304100.60**	
Community Transition Services Total:						**1108.72**
Community Transition Services	Unit	1	1.00	1108.72	**1108.72**	
Environmental Modifications Total:						**21803.64**
Environmental Modifications	Unit	3	1.00	7267.88	**21803.64**	
Family and Caregiver Training Total:						**17739.52**
Family and Caregiver Training	Year	8	1.00	2217.44	**17739.52**	
Music Therapy Total:						**141940.40**
Music Therapy	1/4 Hour	70	163.00	12.44	**141940.40**	
Occupational Therapy Total:						**20.76**

Occupational Therapy	1/4 Hour	1	1.00	20.76	**20.76**	
Personal Emergency Response System Total:						**161.48**
Personal Emergency Response System	Each	2	2.00	40.37	**161.48**	
Physical Therapy Total:						**20.90**
Physical Therapy	1/4 Hour	1	1.00	20.90	**20.90**	
Psychological Therapy Total:						**18.57**
Psychological Therapy	1/4 Hour	1	1.00	18.57	**18.57**	
Recreational Therapy Total:						**60756.96**
Recreational Therapy	1/4 Hour	22	222.00	12.44	**60756.96**	
Specialized Medical Equipment and Supplies Total:						**11566.44**
Specialized Medical Equipment and Supplies	Each	2	1.00	5783.22	**11566.44**	
Speech/Language Therapy Total:						**52166.40**
Speech/Language Therapy	1/4 Hour	8	312.00	20.90	**52166.40**	
				GRAND TOTAL:		**19146648.50**
				Total Estimated Unduplicated Participants:		**530**
				Factor D (Divide total by number of participants):		**36125.80**
				Average Length of Stay on the Waiver:		346

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**6199.20**
Adult Day Services	1/2 Day	2	84.00	36.90	**6199.20**	
Day Services Total:						**888912.90**
Day Services	Day	135	142.00	46.37	**888912.90**	
Rent and Food for Unrelated Live-In Caregiver Total:						**676.96**
Rent and Food for						

Unrelated Live-In Caregiver	Month	1	1.00	676.96	**676.96**	
Residential Habilitation and Support Total:						**18381442.50**
Residential Habilitation and Support	Day	538	375.00	91.11	**18381442.50**	
Respite Care Total:						**276168.96**
Respite Care	1/4 Hour	183	288.00	5.24	**276168.96**	
Adult Foster Care Total:						**314063.00**
Adult Foster Care	Month	10	10.00	3140.63	**314063.00**	
Behavioral Support Services/Crisis Assistance Total:						**1479374.16**
Behavioral Support Services/Crisis Assistance	Month	388	11.00	346.62	**1479374.16**	
Community Transition Services Total:						**1147.52**
Community Transition Services	Unit	1	1.00	1147.52	**1147.52**	
Environmental Modifications Total:						**22566.75**
Environmental Modifications	Unit	3	1.00	7522.25	**22566.75**	
Family and Caregiver Training Total:						**20655.45**
Family and Caregiver Training	Year	9	1.00	2295.05	**20655.45**	
Music Therapy Total:						**162648.64**
Music Therapy	1/4 Hour	77	164.00	12.88	**162648.64**	
Occupational Therapy Total:						**21.48**
Occupational Therapy	1/4 Hour	1	1.00	21.48	**21.48**	
Personal Emergency Response System Total:						**167.12**
Personal Emergency Response System	Each	2	2.00	41.78	**167.12**	
Physical Therapy Total:						**21.63**
Physical Therapy	1/4 Hour	1	1.00	21.63	**21.63**	
Psychological Therapy Total:						**19.22**
Psychological Therapy	1/4 Hour	1	1.00	19.22	**19.22**	
Recreational Therapy Total:						**68624.64**
Recreational Therapy	1/4 Hour	24	222.00	12.88	**68624.64**	
Specialized Medical Equipment and Supplies Total:						**11971.26**
Specialized Medical Equipment and Supplies	Each	2	1.00	5985.63	**11971.26**	
Speech/Language Therapy Total:						**60931.71**

Speech/Language Therapy	1/4 Hour	9	313.00	21.63	**60931.71**	
				GRAND TOTAL:		**21695613.10**
				Total Estimated Unduplicated Participants:		**580**
				Factor D (Divide total by number of participants):		**37406.23**
				Average Length of Stay on the Waiver:		347

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**6646.80**
Adult Day Services	1/2 Day	2	87.00	38.20	**6646.80**	
Day Services Total:						**973909.06**
Day Services	Day	139	146.00	47.99	**973909.06**	
Rent and Food for Unrelated Live-In Caregiver Total:						**700.65**
Rent and Food for Unrelated Live-In Caregiver	Month	1	1.00	700.65	**700.65**	
Residential Habilitation and Support Total:						**20274688.60**
Residential Habilitation and Support	Day	557	386.00	94.30	**20274688.60**	
Respite Care Total:						**305383.20**
Respite Care	1/4 Hour	190	296.00	5.43	**305383.20**	
Adult Foster Care Total:						**357560.50**
Adult Foster Care	Month	11	10.00	3250.55	**357560.50**	
Behavioral Support Services/Crisis Assistance Total:						**1726305.00**
Behavioral Support Services/Crisis Assistance	Month	401	12.00	358.75	**1726305.00**	
Community Transition Services Total:						**1187.69**
Community Transition Services	Unit	1	1.00	1187.69	**1187.69**	
Environmental Modifications Total:						**31142.12**
Environmental						

Modifications	Unit	4	1.00	7785.53	**31142.12**	
Family and Caregiver Training Total:						**21378.33**
Family and Caregiver Training	Year	9	1.00	2375.37	**21378.33**	
Music Therapy Total:						**180221.60**
Music Therapy	1/4 Hour	80	169.00	13.33	**180221.60**	
Occupational Therapy Total:						**22.23**
Occupational Therapy	1/4 Hour	1	1.00	22.23	**22.23**	
Personal Emergency Response System Total:						**172.96**
Personal Emergency Response System	Each	2	2.00	43.24	**172.96**	
Physical Therapy Total:						**22.39**
Physical Therapy	1/4 huor	1	1.00	22.39	**22.39**	
Psychological Therapy Total:						**19.89**
Psychological Therapy	1/4 Hour	1	1.00	19.89	**19.89**	
Recreational Therapy Total:						**76314.25**
Recreational Therapy	1/4 Hour	25	229.00	13.33	**76314.25**	
Specialized Medical Equipment and Supplies Total:						**12390.26**
Specialized Medical Equipment and Supplies	Each	2	1.00	6195.13	**12390.26**	
Speech/Language Therapy Total:						**64886.22**
Speech/Language Therapy	1/4 Hour	9	322.00	22.39	**64886.22**	

GRAND TOTAL:	**24032951.75**
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**40054.92**
Average Length of Stay on the Waiver:	357